MENTAL ILL HEALTH IN NURSING AND MIDWIFERY EDUCATION: A CRITICAL DISCOURSE ANALYSIS

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PHD

2017

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Submitted for the Degree of

Doctor of Philosophy

Faculty of Health Studies

University of Bradford

2017

Abstract

Key Words: Critical discourse analysis, discourse-historical approach, mental health, nursing and midwifery education, disability, reasonable adjustments, nursing and midwifery students.

Students diagnosed with long-term mental health conditions have been the focus of policy development for over a decade. Student mental health is on the increase and universities are legally obliged to make reasonable adjustments for disabled students. Therefore it is crucial that nursing and midwifery education provides an inclusive learning environment, while maintaining fitness to practice standards.

The focus of this study was to explore how discourses of mental health, reasonable adjustments and fitness standards influence nursing and midwifery education for students with a mental health condition. Principles of Wodak's (2001) critical discourse analysis approach, which gives prominence to dominant discourses, their justifications and persuasive nature was utilised. Ten key written texts and 23 semi-structured interviews with students, lecturers and clinical mentors were conducted to acquire the constructions of mental health, reasonable adjustments and fitness requirements.

The findings show that the dominant discourses attributed to students experiencing mental ill health were around medicine, difference and blame, all of which reinforced mental health stigma. In addition, mental health discourses within both verbal and written texts were not underpinned by disability discourses, allowing the exclusion of students who disclose mental ill health from accessing reasonable adjustments. In conclusion, students considered to have a mental health label faced discriminatory barriers and legislative and regulatory requirements of equality were not implemented.

Acknowledgements

I would like to thank the following people, who have supported me and contributed to the completion of this research. Firstly I would like to thank Doctor Christine Dearnley (University of Huddersfield), for giving me the opportunity to research student mental health, for her immeasurable patience and academic mentorship. I would also like to thank Doctor Melanie Cooper (University of Bradford) for her philosophical and methodological knowledge and for acknowledging my need to delve deeper. Both made the research journey more enjoyable through humoured and supportive supervision.

To my partner, Charlotte, without her patience, spelling talents and belief in my ability to complete my thesis, I would have had many more moments of doubt. While I am sure she won't miss my constant interruptions about the most appropriate word to use in a sentence or the correct way to apostrophe the S, I will miss working alongside her in our home office.

Thank you also to all the people who voluntarily gave me their time to participate in this research and allowed me personal and professional access to their thoughts on mental ill health. Without your involvement, there would not be a thesis.

I would like to thank all my friends for providing me with much needed entertainment and support away from my computer.

Finally I would like to thank Andrea Cassidy who taught me during my Master's Degree. It is her who placed the idea of doing a PhD in my head. With a little bit of convincing I was able to take the plunge.

Table of Contents

Figures

Tables

Chapter 1: Introduction

1.1 Overview of the study

The overall aim of the study is to add to the widening participation agenda by identifying how nursing and midwifery education can deliver an inclusive educational environment in order for students experiencing mental ill health to reach their full potential. The Disability Discrimination Act (DDA) (HMSO, 1995) has played a significant role in challenging mental health discrimination and oppression through the introduction of reasonable adjustments in order to meet peoples' needs. The act was amended in 2001 through the Special Educational Needs and Disability Act (SENDA) (HMSO, 2001). Since 2002, it has been the responsibility of universities to ensure all disabled students, including those experiencing mental ill health can access a variety of educational programmes. To achieve this, universities are required to anticipate disabled students and make necessary adjustments. In addition, those adjustments unanticipated can be met through individualised adjustments for students considered disabled as defined in statute. A failure to do so and to treat disabled people less favourably without justification is considered discriminatory.

Since this piece of legislation was introduced, there has been an increase of students with disabilities within higher education (Higher Education Statistics Agency (HESA), 2016a). Despite this, research suggests that disabled students still face numerous barriers on a regular basis. To qualify as a nurse or midwife, students must meet the Nursing and Midwifery Council's (NMC) fitness to practice standards. However the literature does not tell us much about the disabling barriers of nursing and midwifery students who have a mental health condition and the use of reasonable adjustments. No studies have delved deeper and explored peoples' understanding of these concepts and how they influence students nursing and midwifery education success. Therefore the purpose of this PhD study was to respond to the gap in knowledge and dominant discourses around

mental ill health, reasonable adjustments and NMC fitness requirements. This study aimed to go beyond the lived experiences of disability discrimination by examining how dominant discourses create meaning and influence social relations of power within nursing and midwifery education.

This is the first study to explore the dominant discourses utilised both in written and verbal text in the context of nursing and midwifery education, student mental ill health and reasonable adjustments. As the prevalence of student mental ill health is growing, alongside the NHS's (2010) desire to provide a workforce that represents the community it serves, it is pertinent to ensure nursing and midwifery education is inclusive. This study is able to contribute to eliminating the barriers faced by students experiencing mental ill health by illustrating how discourses of mental ill health and reasonable adjustments bring about disabling practices. The research concentrated on answering the following research questions:

1. What discourses influence students, lecturers, mentors and university and NMC policies when referring to student mental health?

2. How do student, lecturers and mentors conceptualise their roles in the student's placement journey with regards to reasonable adjustments and fitness to practice requirements?

3. To what extent do dominant discourses, as they currently exist, influence students diagnosed with a mental health condition?

1.2 Brief description of the philosophical position

Before exploring the pertinent literature regarding students with a mental health diagnosis during their nursing and midwifery education, I felt it paramount to establish the study's philosophical position. Prior to this, my perspective around disability was similar to the social model of disability, whereby students with a mental health condition are disabled by societal

forces like attitudes and norms which employ exclusionary practices. In contrast, the medical model places disability onto the students' individual and medical identity which permits the focus on changing the individual in order to play a role in society (Oliver, 1990). This model is underpinned by social constructionism, whereby disability is socially constructed by societal processes that language and meanings are attributed to (Burr, 2003).

As a result of exploring ontological and epistemological paradigms further, I was introduced to critical realism. This philosophical position accepts a social constructionist epistemology but argues that epistemology cannot be conflated with ontology. In the context of mental ill health, a critical realist position asserts that theories of mental ill health transform over time, albeit slowly (Archer, 1995), but the condition being referred to still has a real entity and is therefore not reduced to what we know about it. Furthermore, unlike social constructionism, critical realism accepts causality, in that people have the power to speak or allocate resources on account of their role within an institutional structure (Sayer, 2000). A full discussion of the philosophical position and its relevance to this study is presented in chapter four.

1.3 Brief explanation of terminology

Mental ill health can be considered a protected characteristic within the disability definition as stated in the Equality Act (HMSO, 2010), even though studies have reported people who experience mental ill health do not consider themselves to be disabled (Riddell et al., 2004; Tinklin et al., 2005; Stanley et al., 2007a; Beresford et al., 2010). Despite this, ascertaining the most appropriate terminology for mental ill health within this study was an arduous task. It was felt important due to its implications on participants' and readers' perceptions as well as being consistent with the philosophical framework of critical realism. Throughout this report, 'mental ill health' will be used in respect to other people involved in the study, who preferred this term. It can be argued that this term is underpinned by medicalisation and

therefore has the power to reinforce a medical model of disability. Nonetheless, to be eligible for reasonable adjustments, students are required to have a mental health label, but may not consider themselves to have a mental health condition or feel like they have been given the most appropriate diagnosis. For this reason, the term ‘mental health label’ will also be used consistently throughout. An in-depth discussion on the various terms used to denote mental health labels has been presented in detail below (see 2.3).

1.4 Personal statement

My personal and professional experiences became the catalyst for an interest in mental ill health generally, not just amongst the student population. My introduction to disability was through growing up with a disabled brother, which influenced my captivation and attraction towards a career in disability equality. My professional background has been predominantly within advocacy; a sector which focuses on service user equality. Previous work has been dominated by dialogues of impairment, functional limitations and knowledge created by professionals and challenged by advocates, of which I include myself. Therefore, it can be argued that my personal and professional background has played a significant role in choosing this area of study. A position supported by Phillips and Pugh (2010) who suggest the research topic chosen should be of interest to the researcher. It is important to note that despite some of my advocacy experience taking place within the NHS environment, my professional background does not stem from nursing or midwifery professions. Therefore, unlike most other research projects around nursing and midwifery students with disabilities, my research has been predominately from a disability lens and not from a health professional position.

As a dyslexic person who considers self to be disabled, my prior knowledge as a disabled person could be argued as advantageous, in that my

disability analytical lens allowed me to read data in a way that may not be present among non-disabled perspectives. This has led to an alternative to the current conception of student mental ill health and processes around reasonable adjustments during nursing and midwifery education. It is argued that this alternative will benefit students and educators by highlighting and challenging discourses underpinned by mental health stigma and disability discrimination. This allows for current processes to be critically analysed and other approaches recommended, with the view to refining and enhancing the equality agenda already established in legislation and policy.

1.5 Structure of the thesis

This chapter has presented an initial background to the personal context choice of terminology, the aim of the study, research questions, followed by a brief introduction of how the study was conducted.

Chapter two introduces the concept of mental ill health and its historical significance. This is followed by a synopsis of the various terms used to denote mental ill health and why an array of terms is used throughout the thesis. The chapter also presents an introduction the issues associated with mental health stigma. Chapter two will end with the legal and regulatory framework of nursing and midwifery and disabled students.

Chapter three introduces a critical overview of the literature regarding student mental health in the context of higher education generally and nursing and midwifery education specifically. This is accompanied by an exploration of the experiences faced by, and perceptions of, students and educators around disclosure and reasonable adjustments. The chapter concludes with the research questions, developed as a result of the gaps within the literature.

Chapter four provides a comprehensive overview of the potential ontological and epistemological positions in relation to concepts of mental health and research design. In particular, this chapter focuses on a critical realist ontology and epistemology. Following an examination of the potential methodological frameworks, a number of discourse analytic methods were considered. Critical discourse analysis was the approach adopted, giving prominence to theoretic concepts such as power, ideology and hegemony (Reisigl and Wodak, 2009), which satisfies a critical realist framework. I have drawn specifically from a discourse-historical approach, which aims to analyse the justifications for discursive strategies and their persuasive nature.

Chapter five presents a detailed explanation of the data collection methods and procedures utilised. Seven NMC and three university policy and procedures form the documentary data set, followed by 23 semi-structured interviews. A description of the analysis, ethical considerations and research quality follows in order to ensure the reader can assess the trustworthiness of the research.

Chapter six provides the key findings of the study in relation to the three research questions. The findings are presented into three dominant discourses; medical, difference, and blame. Each of these incorporates their own discourse strands and is presented alongside quotations from both verbal and written texts.

Chapter seven discusses the findings and how they link to existing literature and theory. This chapter will also demonstrate how they relate to, and influence, educative and clinical practice and policy.

Chapter eight explores the future by recommending a new way of enabling students who identify with a mental health condition and qualify for reasonable adjustments. The focus of this chapter is about how a new approach to student mental health could positively affect all stakeholders.

Chapter nine concludes the research with my reflections on the process undertaken, followed by a summary of the findings in relation to the research questions and the research limitations with regards to both the design and my own influence of being a disabled researcher. The chapter is brought to a close with a number of recommendations for further practice and the potential of other research projects which may continue with the emancipation of disabled students.

Chapter 2: Background

2.1 Introduction

The aim of this study was to improve the learning experiences of nursing and midwifery students with a mental health label. Before any research questions could be constructed, a historical overview of mental ill health was conducted. This allows for the historical context to be taken into account later on in the study when dominant discourses identified in the text are shown to be discursively reconstructed over time. The chapter then presents a critical analysis of the concept, prevalence, social inequality and stigma attributed to mental ill health. An overview of nursing and midwifery education and legislative duties towards disabled students which inform equality policy and procedures will be discussed, with the intention of providing a contextual basis for the study.

2.2 Brief history of mental ill health

It is argued that we are able to understand what is present if we explore the past (Read, 2004). Therefore this section begins with a brief historical synopsis, not just to illustrate written histories, but to provide an understanding of what will be discussed later in relation to contemporary mental health discourses. Mental ill health has been transformed over the centuries, ranging from people being deemed ‘wise’ and ‘divinely inspired’ in medieval times to ‘fools’ during the Renaissance (Porter, 2002). Prior to medical intervention, people experiencing mental ill health were kept on vessels known as ‘ships of fools’ (Foucault, 1988), then later tortured as a way of dealing with demoniacal possession (Porter, 2002).

The Renaissance period (14th to 17th century) saw the introduction of mad doctors who accused people, mainly women, of witchcraft. Medical interventions for such included drilling holes in peoples’ heads to let the devil out (Porter, 2002). During this period the infamous Priory of St Mary of

Bethlam in London was used to detain what was known as ‘lunatics’. Prior to the Great Confinement during the mid-seventeenth century people were able to live among the general public, but this soon changed as the concept of deviancy was born (Rogers and Pilgrim, 2001).

The Great Confinement was a time in history whereby people were considered a moral issue by equating madness to idleness, triggering the introduction of workhouses (Foucault, 1988). The idea was to institutionalise people to prevent idleness, the source of all disorders and contain unreason (Foucault, 1988). This was dominant in the mid-seventeenth century and carried out by the church in partnership with the government. This period in history was not focused on caring for people, but excluding those who were considered ‘abnormal’ from society. Foucault (1991) argued that by controlling the ‘abnormal’, meant the ‘normal’ could exist. This paved way for the institutions to instruct residents to meet their moral duty to work and rid any notions of imaginary freedom and difference (Foucault, 1988).

It was considered that mental ill health was better treated with torture rather than medicine as it was thought people would recover much quicker (Porter, 2002). Such interventions included cold water immersion and burning with hot irons, to name but a few. The conditions in the asylums were widely criticised as being inhumane. However, contrary to this criticism, it was still accepted until 1815 that public viewing of residents in such conditions was a London tourist attraction (Foucault, 1988). It wasn’t until the early 1800s that living conditions within the institutions were questioned. Pinel in France implemented humanitarian approaches which aimed to put an end to the previous institutional abuses. In England, it was the Quakers who played a major role in changing these practices. William Tuke wanted to provide humane and therapeutic interventions instead of barbaric treatments of the time. He called his approach ‘moral treatment’ which allowed patients freedom and dignity using reward and punishment (Burton, 2009; Wise, 2012). However this approach was challenged by

Foucault (1988) as he thought that patients, who were once prisoners, were treated like minors, as they had to behave themselves or punitive action was implemented.

This historical period was the start of defining what was termed madness, was reconstructed into an illness (Foucault, 1988), a position still present today. This change resulted in the 1828 Act to Regulate the Care and Treatment of Insane Persons in England, allowing people to have visitation rights and be discharged (Rogers and Pilgrim, 2001). Its intention was to protect people from incarceration and abusive treatment (Wise, 2012). To ensure protection, two certificates of mental ill health were required by two separate doctors, a provision still current today (HMSO, 2007). However, unlike today, only one certification was required from a medical person for non-private patients. The other certification could have been acquired from a magistrate, clergyman, school teacher, Poor Law officer or people in other civic roles (Wise, 2012).

The Lunatics Act of 1845 gave rise to the emergence of the profession of psychiatry in 1846, allowing ‘madness’ to be reinvented as a medical concern in need of segregation and control (Foucault, 1978; Rogers and Pilgrim, 2001) operating within the state. Also in 1845 The Alleged Lunatic Friends Society was established by John Thomas Perceval who personally experienced time in an asylum. The society advocated for over 70 patients, exposing abuses in Bethlam Hospital. The most notorious case was that of Thomas Wakley, MP, the founder of The Lancet (Wise, 2012).

During the 1800s the British psychiatrist Henry Maudsley believed that ‘lunatics’ were the result of evolution and not fit for treatment, a position not shared, as other psychiatrists of that time believed mental ill health was a disease (Rissmiller and Rissmiller, 2006). The previous preoccupation with control was shortly followed by a formal system of diagnosis, traced back to Emil Kraepelin and his work on dementia praecox (re-labelled as schizophrenia) (Bentall, 2003). This system allowed mental ill health to be classified as a biological condition (Pilgrim, 2009). This is still consistent

today, as a diagnosis which stems from biological models of mental health is essential. Without such a diagnosis, a student cannot demonstrate their eligibility for reasonable adjustments.

Some biological assertions are not accepted today including ‘drapetomania’, a psychiatric disorder defined in 1851 as a disease which made slaves run away from their masters. Also hysteria was commonly diagnosed in the late nineteenth century and was mostly among women, yet the diagnosis is unheard of today. More recently, homosexuality, up until 1980, was categorised as a mental health disorder. On the other end of the spectrum, attention deficit hyperactivity disorder (ADHD) has widely been diagnosed since the 1980s. Church (2004) argues that the labelling of this diagnosis is endemic in America whilst in the UK it is thought to be more common in boys than girls and estimated to affect two to five per cent of school children (NHS, 2016).

The start of the twentieth century saw the introduction of Freud, mainly in the US but not in the UK. His psychoanalytical model of mental ill health, especially schizophrenia, was to be considered as unconscious conflicts stemming from childhood (Burton, 2009). During this time, people in the UK were categorised as ‘moral defectives’ as stated in the Mental Deficiency Act 1913. This included unmarried mothers.

The 1900s also saw the Nobel Prize winner, Dr Alexis Carrel posit that people with mental health labels, alongside criminals, should be disposed of and euthanased by gas. Not long after, men from the First World War were coming home with what was referred to as ‘shell shock’. Prior to understanding the impact of war on mental health, men were considered unpatriotic, synonymous with treason. However, as a consequence of ‘shell shock’, the environment was now being considered as having causality of mental ill health (Rogers and Pilgrim, 2001). Today, ‘shell shock’ is more commonly referred to as post-traumatic stress disorder (PTSD) (Pilgrim, 2015). It was also believed that the use of alcohol and drugs following the

Second World War became a medical condition rather than a moral or criminal problem (Rogers and Pilgrim, 2001).

The disregard for the lives of people with a mental health label was evidenced during the Second World War. Documentation has been able to illustrate the experiences on people considered mentally ill during the Nazi human experiments. It is unknown how many experiments took place, leaving some unanswered questions, but as a result of barbaric practices, such as sterilisation and euthanasia murders, contemporary scientific ethical procedures were formed. It wasn't until the start of the twenty first century that authorities recognised the extent of the experiments (Weindling, 2015).

During the twentieth century, the Diagnostic and Statistical Manual of Mental Disorders (DSM) currently in its fifth edition (DSM-V) (American Psychiatric Association, 2013) was created. The manual has been criticised as an instrument of social control (Kirk and Kutchins, 1992) and promotes labelling which allows social issues to be replaced with individual pathology (Bentley, 2005). This argument prevails as diagnosis is based on symptoms verbalised by the patient rather than biological signs and is why claims of aetiology is absent from DSM (Pilgrim, 2009). The other accepted system is the International Classification of Diseases (ICD), developed by the World Health Organization since 1946, currently in its tenth version; the eleventh expected in 2018 (World Health Organization (WHO), 2016). Like DSM, criticisms concerning this classification system are widely published. ICD-10 is considered too complex to use as medical practitioners are expected to refer to over 65,000 diagnostic codes. While these are reduced depending on the medical specialism, it can be argued that the number is still substantial.

The twentieth century also included the creation and dominance of brain imaging, genetic research and pharmacological advancements. This has enabled a return to biological ideologies rather the recent psychoanalytical

domination at the start of the century (Burton, 2009). Ilyas and Moncrieff (2012) posit that the size of the pharmaceutical industry is an illustration of how prevalent mental ill health is within the UK. They suggest that an estimated 10 per cent of the NHS prescription allocation is consumed by pharmaceuticals specifically for mental ill health. Despite the fact that the majority of people diagnosed with specific labels are prescribed some form of medication, many people do not respond to such medical interventions and for some result in devastating consequences. Mosher et al. (2004) suggests the use of psychiatric drugs is increasing at an alarming rate across the globe. A further concern is that pharmaceuticals are prescribed for the wrong reasons and that the route cause may be ameliorated by talking (Jorm, 2000) and alternative therapies (Jorm et al., 2004).

Other forms of medical interventions include major tranquillisers which have been shown to restrict auditory hallucinations. Electroconvulsive therapy (ECT), still active today, is prescribed as a last resort and evidence would suggest it can ameliorate severe depression (Rogers and Pilgrim, 2010). The treatment has been widely criticised since its conception, but more recently, speaking at a mental health conference, Professor McKenna, Vice Chancellor of Research and Innovation at Ulster University, asserted that ECT would become an intervention of the past and be considered barbaric (Merrifield, 2015).

2.3 The concept of mental ill health

The concept of mental ill health has changed throughout the centuries and is dependent on the assumptions made from that historical period (Foucault, 1988). Mental health is very broad and potentially wider than the focus of this study as contemporary meanings incorporate mental wellbeing, a term introduced by WHO (Pilgrim, 2009), as well as terms meaning mental ill health. Mental health is not clearly defined by WHO but asserts mental health as *“a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life,*

can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2014). This definition is somewhat unclear and open to varying interpretations. For instance, 'can cope with the normal stresses of life' suggests that there is a normative judgement on what is considered normal as no definition of normal is provided. Furthermore, the definition demonstrates a medical model of disability approach in that mental health is dependent on the individual. It disallows any social factors which may influence the person's ability to 'work productively and fruitfully'. In the context of this study, this definition might influence nursing and midwifery participants' understanding of mental ill health.

Previous definitions have relied on an 'absence of disease' approach whereby the focus is on diagnosis rather than the current definitions which focus on health. In light of this, mental health will not be explored within this chapter, but is accepted as a positive term or a euphemism for services aimed at people experiencing mental ill health (Pilgrim, 2009). It is also important to note that a person with a mental health diagnosis can still be mentally well. As a consequence of this position, the study does not accept that mental ill health is the absence of mental wellbeing (Poppy, 2016).

A review of the literature illustrated the complexity of identifying what is considered to denote mental ill health due to the absence of universal acceptability and each term having its own critic. An example of the lexical choices given to, or chosen by, people themselves include 'mental health difficulties' (Duggan et al., 2002; Riddell and Weedon, 2014; Howlin et al., 2014b), 'psychiatric disabilities' (Corrigan and Watson, 2002; Megivern et al., 2003; Olney and Brockelman, 2003; Brockelman et al., 2006; Mowbray et al., 2006), 'mental health disabilities' (Sowers and Smith, 2004), 'mental health concerns' (Griffiths et al., 2010), 'mental impairments' (Tee et al., 2010) and 'mental health consumers' (Ralph, 2002; Bos et al., 2009). The dominant term used by many within the literature is 'mental health problems' (Manthorpe and Stanley, 1999; DRC, 2006; Stanley et al., 2007b; Hamilton, 2010; Department of Health, 2011a; Barrett and Jackson, 2013;

Time to Change, 2013). Fawcett and Karban (2005) identified other terms and phrases within the current field of mental health including people experiencing ‘mental distress’, ‘mental disorders’, ‘severe psychological distress’ and ‘madness’. A review of terminology used at the UK university under investigation also identified similarities. For instance in one relevant document, ‘mental health issues’, ‘mental health problems’ and ‘mental health difficulties’ were used in the same text concurrently (The university, 2012).

Within the current literature, person-first language was also utilised and included phrases like ‘people with a mental health issue’, ‘people with a mental illness’ (Corrigan and Watson, 2002; Medical Research Council (MRC), 2010; Roe et al., 2014; Pilgrim, 2015) and ‘people diagnosed with a mental health condition’. Granello (2016) and Shakespeare (2014) advocate the use of person-first language, as it influences how we perceive mental ill health. However Granello (2016) found paucity within the literature and as a response, conducted a survey amongst three groups of people within the US; undergraduate college students in general education courses; adults using a community centre which promotes health and wellbeing and counsellors both qualified and in training. The study found a significantly lower tolerance for people linguistically referred to as ‘the mentally ill’ than those referred to as ‘people with mental illnesses’. For instance, college students and counsellors were more likely to consider a person as a threat to society, and community centre users were less empathic and compassionate, when ‘the mentally ill’ was used.

Other mental health and disability organisations and movements have demanded language puts the individual first and therefore challenges language which describes the person by their disorder or condition. This has its advantages, in that people have multiple identities, but by describing a person by their disorder or condition has the potential to fail to see the intricacy of being a person (Rovinelli Heller and Gitterman, 2010). Whatever language is used to describe the person, it is the opinion of various

scholars (Szasz, 1973; Foucault, 1988; Rogers and Pilgrim, 2003; 2010; Laing, 2010), that those recognised, or who recognise themselves, as experiencing mental ill health have had these terms applied to them by the medical profession, academics and others.

From the perspective of the individual, various terms have been identified. These include ‘survivor’ of the mental health service (Campbell, 1996; Beresford et al., 2010), however this term has been criticised due to its association with the Holocaust (Rissmiller and Rissmiller, 2006). Fawcett and Karban, (2005) identified terms like ‘ex-patient’ and ‘service user’, all of which depend on how the individual or group view themselves or are viewed by others. This language is problematic as students don’t always seek professional help (Reavley et al., 2010; Hunt and Eisenberg, 2010). In the context of higher education, the National Union of Students (NUS) (2013) found only 10 per cent had gone through counselling. Therefore, using words like ‘service users’ or ‘patients’ will only be appropriate if professional intervention was sought. Rovinelli Heller and Gitterman (2010) acknowledge the importance of service user-led definitions, like the advocacy group National Association for Mental Illness. However, they assert that mental health social work professionals, seen as 'experts', prefer the term ‘condition’ rather than ‘illness’, which arguably contradicts the ideological premise of user-led definition.

Within statute, the term ‘impairment’ is preferred as it indicates a social model approach to disability, whereby impairment refers to the student’s mental health condition, whereby as disability is caused by the way society is structured rather than the student’s impairment (Oliver, 1986). There is a move towards creating a social model of mental health but Beresford et al. (2010) found the word ‘impairment’ a contentious issue amongst some mental health service users. The study could not find a consensus as some agreed with the term, while others did not identify with the word due to its association with disabled people, indicating disability still as an undesirable identity (Grue, 2013).

Due to this complexity, and prior to data collection, two people regarded as ‘experts by experience’ (see 5.3 for further discussion) were consulted about what they considered as the most appropriate terminology. Similar to language used by Department of Health (2011a), ‘mental ill health’ was their preferred choice of words. This term was used consistently throughout the interviews unless other terms were used by participants. However it is accepted that people who have experienced or currently experiencing mental ill health are not a homogenous group, and should be able to use whatever term they wish (Sanderson-Mann and McCandless, 2006). For this reason, other terms will be utilised within this study. Similar to Olney and Brockelman (2003), I have chosen to use the term ‘mental health label’ when referring to a non-specific diagnosis afforded to people, allowing for the diagnosis to be differentiated from the experience or self-perception. Furthermore, the word ‘disability’ will be used when referring to all people considered disabled under statute including mental ill health. However, when mental ill health is excluded from the discussion around disability, language such as ‘physical’ or ‘learning disabilities’ will be utilised.

2.4 Prevalence of mental ill health

Mental ill health can be long lasting and experienced multiple times throughout one’s lifetime. Other experiences of mental ill health may only happen once and for shorter periods of time (Department of Health, 2011a). For instance, a person may have a mental health label of bipolar disorder and potentially experience symptoms sporadically throughout their life. Other mental health experiences, for example depression, may be a one-off experience. Despite this diverse manifestation, mental ill health is thought to be experienced by one in four people (Rogers and Pilgrim, 2003; Department of Health, 2011a) in any one year and is estimated to affect 16.7 million people in the UK alone, accounting for 15 per cent of all disabilities (MRC, 2010). Mental ill health is predicted to be the largest burden of illness across the globe within the next decade (Mathers and Loncar, 2006).

At least three-quarters of adults in the US who experience a long-lasting mental health condition will have experience by their mid-20s (Kessler and Wang, 2008). The Australian Bureau of Statistics (2007) study found that three-quarters of all people who experience mental ill health do so by the time they are 25 years old. Furthermore, the study reported that one in five adults experience mental ill health at some point in the 12 months prior to the study taking place. In comparison, it is estimated that one in six people experience severe anxiety or depressive conditions at any one time in the UK (Sainsbury Centre for Mental Health, 2003). A recent Scottish survey (Reid et al., 2013) reported that 26 per cent of people had experienced mental ill health and two-thirds of people said they knew of a person who has experienced mental ill health.

The prevalence of mental ill health among the adult population is significant to nursing and midwifery education as it seems likely that educators will come across students experiencing mental ill health. The nursing and midwifery environments in the UK (Deary et al., 2003; Francis, 2013; Royal College of Nursing (RCN), 2013) and internationally (Bayoumi et al., 2012) may also influence a student's mental well-being as both professions are recognised as stressful. Nurses and midwives have reported experiencing verbal or physical abuse from patients or bullying and harassment from managers and colleagues (RCN, 2013). Students have also reported increased stress due to financial concerns, long hours, workload and unsupportive practices (RCN, 2013).

As a result of work-related stress, depression or anxiety, the Labour Force Survey data estimates that 11.4 million work days were lost in the UK during 2008 and 2009 (Department of Health, 2011b). Despite this, statistical data with regards to the prevalence of mental ill health among nursing and midwifery students was not found. However, nursing and midwifery staff report that high staff shortages (NHS, 2010; Department of Health, 2016a), workloads, a bullying and harassment culture and increased demands from patients including verbal and physical violence,

have impacted on mental wellbeing (RCN, 2013). Long shifts and an absence of appropriate breaks have also resulted in nurses and midwives feeling fatigued, all of which influences the quality of care provided (RCN, 2013).

2.5 Social Inequality

It is widely accepted that mental ill health is related to particular societal circumstances (Church, 2004). An individual's socio-economic status is understood to significantly influence a person's mental health. It is suggested that those considered to occupy a lower social class are exposed to environmental and social stresses which create a higher rate of mental ill health. This relationship is evident in a systematic review of the distribution of common mental disorders within Europe over the past 25 years. Fryers et al. (2005) found that people of lower socio-economic status are at a disadvantage, as people experience higher frequencies of 'common mental disorders' associated with poor education and unemployment. Student-centred studies have reported similar findings. Cleary et al. (2012) found that nursing students from poor socio-economic backgrounds were three times more likely to experience depression, anxiety or report suicidal ideation than their peers. However poverty is not a guarantor of mental ill health, nor does its absence necessarily lead away from mental ill health. Accordingly, Hurst (2007) suggests illness causes a person to descend down the socio-economic scale, which Markowitz (1998) argues is influenced by public stigma.

2.5.1 Mental health stigma

Contributing to social inequality is the experience of mental health stigma. Goffman's (1963, p. 3) seminal work defines stigma as 'an attribute that is deeply discrediting'. Link and Phelan (2001) suggests that stigma is underpinned by power relations and allows people to be separated into 'us' and the stigmatised group, 'them'. Public stigma influences all aspects of a

person's life (The Mental Health Foundation, 2000) and people with a mental health label are more likely to be stigmatised than any other person (Thornicroft, 2006). People stigmatise those who demonstrate certain attributes elicited from common stereotypes (Corrigan, 2007) but can be most harmful when people reinforce these stereotypes by prejudicial responses, discriminatory practices and reactions (Corrigan et al., 2009).

A survey conducted in 2008 by the 'Time to Change' campaigning organisation found that 87 per cent of service users felt that stigma and discrimination negatively influenced their life. The survey also found that 71 per cent said that stigma had stopped them doing things they wanted to do in their lives (Corry, 2008) including gaining employment and accessing education, both areas significant to students wanting to pursue a career in nursing and midwifery.

People with a mental health label are more likely to be unemployed than others (Baldwin and Marcus, 2007; WHO, 2011a), partly as a result of employers being less likely to recruit people known to have a mental health label (The Mental Health Foundation, 2002; Thornicroft, 2006; Thornicroft et al., 2009). Some mental health labels are more likely to be stigmatised than others (Mowbray et al., 2006). For instance an estimated 80 per cent of people with the psychiatric label schizophrenia are likely to be unemployed (MRC, 2010) whereas around 40 per cent of people with anxiety or depression are unemployed (The Mental Health Foundation, 2002).

Discriminatory experiences around employment are a cause for concern for nursing and midwifery professions as it has been reported that there is a shortage of nurses and midwives within the NHS (Francis, 2013; Health Education England, 2014; Department of Health, 2016a) which is impacting on the quality of nursing practice and mental health of nursing staff (RCN, 2013). Furthermore, people who lose their job (McManus et al., 2012) or experience unemployment have poorer mental health than those who are employed (Cleary et al., 2012). One participant in a user-led research

project indicated that losing their job was one of the worst things that could have happened (Bodman et al., 2003). The majority of participants identified stigma as the most important reason for not taking up work in the future. Almost all participants illustrated a fear of discrimination if they were to disclose their mental ill health at work. However, The Mental Health Foundation (2000) found that 47 per cent of service users were discriminated at work, suggesting that actual discrimination may substantiate people's fear. It is therefore understandable why nurses and midwives are still reluctant to disclose a mental health label due to this continuing mental health stigma (Gooding and Kane, 2009; RCN, 2013).

Challenging mental health stigma is therefore essential. This is demonstrated by a commitment from the UK government and the NHS who both recognise its deleterious effects on mental wellbeing. For example, according to government policy (Department of Health, 2011a), both mental health intervention and stigma are areas of concern and require additional resources and a change in attitudes in order to meet the needs of people experiencing mental ill health. However, mental health stigma is deep-rooted and has an extensive history (Jamison, 2006), which makes its elimination an arduous task, especially as the prevalence of stigma has not diminished considerably. Despite this, it would be interesting to find out if student and educators' understanding of mental ill health and reasonable adjustments reinforce mental health stigma or play a part in creating a diverse NHS workforce which represents the community it serves (NHS, 2010).

However, what also needs to be explored which contributes to the continuation of mental health stigma is stereotyping. Goffman (1963) asserts that stigma allows people's actual identities to be replaced with perceived identities as a result of stereotypical predications. These are usually pejorative and associated with certain social groups, including those with mental health labels.

2.6 Common stereotypes

The literature repeatedly reveals how mental ill health is connected to a number of stereotypical assertions, making it one of the most undesirable identities (Corrigan et al., 2000). A common stereotypical predication attributed to people with a mental health label is untrustworthy (Link and Phelan, 2001; Imhoff, 2016). Studies have reported this stereotype is still prevalent today. For example, Olney and Brockelman (2003) found that the stereotype influenced decisions not to disclose as students wanted to be considered trustworthy. Prior (2010) found that 74 per cent of people considered women who had previously been patients in a mental health hospital were not trusted to be babysitters. More recently, it can be argued that the reporting of welfare reforms (HMSO, 2012), reinforce this stereotype as the focus has been on benefit fraud by disabled people including people with a mental health label. Hughes (2015) asserts that recent welfare reforms allow people to be re-categorised as fit for work, which has arguably reinforced suspicion, especially as mental ill health can be hidden and fluctuating (Mullins and Preyde, 2013).

Less competence is also a common stereotypical trait (Link et al., 1999; Corrigan et al., 2000; Link and Phelan, 2001; Megivern et al., 2003). Studies have shown that people with a mental health label are perceived as less competent than those who do not (Angermeyer and Schulze, 2001; Sadler et al., 2012). For example prior to the Mental Health (Discrimination) (No.2) Act (HMSO, 2013), there was a restriction of people with a mental illness to participate in jury service or become a company director.

Competency in nursing and midwifery education is essential if students are going to meet the expectations of users of the NHS (Darzi, 2008) and be able to deliver appropriate and effective care (NMC, 2010a). In order to demonstrate competence, students are expected to participate in a programme in both academic and clinical settings. However, research has shown that students considered to have a mental health label are assumed

to be less capable in pursuing education (Mowbray et al., 2006) and meeting fitness to practice standards (Disability Rights Commission (DRC), 2007). In contrast, Gooding and Kane (2009) assert that there is no evidence to suggest that nurses and midwives with a disability are less competent than non-disabled colleagues.

The most endemic and disparaging trait (Jones and Corrigan, 2014), based on a prejudicial norm (Pilgrim, 2015) is the stereotypical predication of violence associated with mental ill health (Link et al., 1999; Angermeyer and Schulze, 2001; Corrigan and Watson, 2004), as a result of fear and stigmatisation (Pilgrim, 2015). There is an overwhelming array of contemporary research literature, conducted using diverse methodologies, which have widely reported it as a stereotype with no regard for evidence (Cutcliffe and Hannigan, 2001; Prior, 2010). This is largely in association with schizophrenia (Link et al., 1999; Durand-Zaleski et al., 2012).

One study widely cited which corroborates the stereotypical view is Swanson et al. (1990). They found that people experiencing psychosis were three times more likely to be violent than people with no diagnosis of mental ill health. However the risk was only seven per cent, which suggests 93 per cent are not violent. Furthermore, it is likely that a person with a mental health label, who was going to be violent, would be in receipt of psychiatric care, have certain disorders and symptoms (Eronen et al., 1998).

Therefore it can be argued that a large majority of people who experience mental ill health are not going to be violent. However, the strength of the stereotype was demonstrated recently in a UK supermarket chain who sold a ‘mental patient’ costume. In 2013 the campaign charity Rethink, backed by a public outcry, successfully challenged and removed this costume from the stores due to its reinforcing stereotype of a violent and murderous character (Anonymous, 2013).

These stereotypes, if prevalent in nursing and midwifery education, could be argued to have a significant impact on students who have disclosed or chosen not to disclose mental ill health. Therefore it would be appropriate to see if nursing and midwifery students, lecturers and mentors have similar stigmatising attitudes and beliefs about student mental health.

2.7 Media influences

Media portrayals of mental ill health sustain and amplify stigma (Angermeryer and Schulze, 2001) by the use of derogatory language, regularly asserting violence (MRC, 2010). A frequently cited study, Philo (1996), conducted in the UK using focus groups found that two-thirds of reported stories which related to mental ill health were associated with violence. This was acknowledged by 40 per cent of participants who believed that most sources of violent stereotypes came from media portrayals. It can be argued that more recent studies suggest this stereotypical predication is still pursued today. For instance the focus of stories around mental ill health is still accompanied by depictions of being a danger to others (Coverdale et al., 2002; Thornicroft et al., 2013) or in association with criminality (Whitley and Berry, 2013). Even when mental ill health is not evident, the perpetrators' mental state form part of the news story (Flynn et al., 2015). Furthermore few stories incorporated personal accounts of mental ill health and, those which did were less negative and reported more on the effects of stigma and overcoming adversity (Coverdale et al., 2002; Chopra and Doody, 2007).

In relation to the reporting of mental ill health generally, Lawrie's (2000) comparative study of UK newspapers reporting of mental ill health and physical illness found that the coverage portrayed more negativity towards mental ill health. The negative articles on physical health were commonly aimed at highlighting bad medical practice, whereas mental ill health articles were aimed at the mental health conditions of patients. For these reasons, the UK 'Time to Change' campaign, led by charities Mind and

Rethink Mental Illness, aims to encourage the media to promote positive attitudes towards those with a mental health label (Time to Change, 2013). In contrast, Pieters et al. (2003) reported a higher number of positive accounts of mental ill health than negative in a Flemish study, but similarly found the negative accounts were more directed towards patients, most of which was reported in tabloid newspapers.

Television is also considered as a contributing factor to the negative portrayal of mental ill health. With a number of programmes at the centre of criticism, it was felt that mental health stigma was reinforced. For instance in the UK, Dr Who was criticised in 2012 for the episode titled 'Asylum of the Daleks' as its underlying message was that mental ill health not only means difference, but will result in being locked away (Doctor Who TV, 2013). In contrast, Channel Four's 'Bedlam' series was praised for its truthful depiction of living with a mental illness and was viewed as having a positive impact on challenging the myths around mental ill health (Anonymous, 2013).

In light of the negative portrayal of mental ill health, the media remains the main source of information for the majority of people (Durand-Zalaski et al., 2012) and specifically for mental health information (Coverdale et al., 2002; Thornicroft, 2006). As nursing and midwifery students and educators are members of the general public who access the media, it was important to find out if participants' understanding of mental ill health is similar to media representations and how they influence practices within nursing and midwifery education. It is argued that this would be especially important in light of technological advancements which facilitate the media to influence people twenty four hours a day worldwide.

2.8 Impact of stereotypes

Stereotypes which maintain the perception of violence are considered the most harmful mental health stigma which can only fuel public stigma

(Sayce, 2000) and social distance (Link et al., 1999; Corrigan et al., 2002; Angermeyer and Matschinger, 2003). As a result of negative attitudes people experience rejection from both individuals and the wider society (Goffman, 1963; Foucault, 1988; Thornicroft, 2006; Pilgrim, 2009).

Social distance can be a response to the perception of violence which leads to fear. There is a plethora of studies which evidence the fear of people who have a mental health label. For instance Angermeyer and Matschinger (2003) found that psychiatric labels increased fear and social distance. Furthermore, if psychiatric labels are presented without any description of symptoms, then social distance is increased (Imhoff, 2016). Similarly, Prior (2010) reported that although 84 per cent of people agreed with the statement 'No-one has the right to exclude people with mental illness from their neighbourhood', only 66 per cent agreed with the statement 'Residents have nothing to fear from people coming into their neighbourhoods to obtain mental health services'. This suggests that a third of people do fear people with a mental health label. Social distance can also be enhanced when certain psychiatric labels are presented without any description of symptoms.

Goffman, (1963) asserts that people with concealable stigmas are able to avoid these consequences as prejudice and discrimination is concentrated on those with observable stigmas. However, it is widely accepted that receiving a mental health diagnosis cannot only trigger a set of stigmatising beliefs towards a person, but can also create self-stigma; a stigma which influences how the person sees themselves (Link and Phelan, 2001). Self-stigma can lower a person's self-esteem and self-worth, especially if they consider the stereotypes to be justified (Corrigan and Watson, 2002; Corrigan et al., 2009; Bos et al., 2009; Beresford et al., 2010).

An impact of self-stigma is label avoidance, whereby people may decide to not seek medical intervention (Corrigan, 2004). It has been reported that both young people and at least a third of adults may not seek medical

intervention (Andrews et al., 2001; Reavley et al., 2010). Thornicroft (2006) argues that this is an underestimation as he asserts the true number is at least half. It is suggested that the number of people who do not seek medical attention is higher among the student population. For instance Hunt and Eisenberg (2010) found three quarters of students with depression in the US did not attempt to access medical help for mental ill health. However, this was partly as a result of not considering themselves as needing help. Similarly, a UK survey conducted by the NUS (2013) reported that only 10 per cent of students had gone through counselling. If appropriate treatment may result in positive outcomes (Cleary et al., 2012) and contribute to the success of nursing and midwifery student's education, it is paramount to explore how educators respond to early signs of mental ill health or disclosure among students.

2.9 Nursing and midwifery education

The Nursing and Midwifery Council (NMC) is the regulatory body for nursing and midwifery professions. The NMC's role as required by the Nursing and Midwifery Order 2001 is to draw up and maintain standards of education, training, conduct and performance of both nurses and midwives within England, Scotland and Wales. The NMC authorises Approved Educational Institutions (AEIs) to deliver nursing and midwifery programmes and maintains a register of nurses and midwives.

Both the nursing and midwifery professions play a crucial role within the NHS, so to perform effectively and provide appropriate patient care, a person has to successfully complete a Baccalaureate degree qualification in nursing or midwifery before being placed on the NMC register (NMC, 2009, 2010a). The NMC requires a high quality of education to be equally distributed between both academic and clinical settings (NMC, 2008b) in order to enable students to meet all fitness to practice standards.

The majority of a lecturer's role will be to provide teaching and assessment within the academic setting. In addition, the NMC expect the lecturer's role

to include student learning within practice through link tutoring (between university and the student's clinical placement), support in mentor development and updating, be a practicing nurse or midwife part of the time or contribute to practice-based research (NMC, 2008b).

Students will come into contact with mentors and sign-off mentors during their clinical placement. These are qualified nurses or midwives, who as a requirement of the Standards to Support Learning and Assessment in Practice (NMC, 2008b), are registered with the NMC. Mentors are required to have completed an NMC mentor programme, attend regular mentor update training and assess students during their placement. The mentor is expected to work with the student and to supervise at least 40 per cent of their time on placement and make assessment decisions about their practice proficiency throughout (NMC, 2008b).

Nurse or midwife mentors, who have met the sign-off criteria as part of their training, are able to sign-off proficiency at the end of student placements. These mentors can only be sign-off mentors to students who intend to qualify in the same field (NMC, 2008b). They are expected to provide one hour per student, per week, for support and assessment to take place. The sign-off mentor will consider all of the assessment evidence and make a decision about their practice proficiency at the end of the placement. Considering their role in a student's placement, it is paramount to investigate their understanding of student mental ill health, reasonable adjustments and fitness to practice standards and how this may influence a student's ability to reach their full potential.

2.9.1 Fitness to practice standards

Students enrolled on a nursing and midwifery pre-registration programme are obliged to register with the NMC when qualified and consequently demonstrate their ability to meet fitness to practice standards (NMC, 2008a). In order to achieve qualification, students need to demonstrate that

their practice ensures safety and efficiency and they have met the standards of proficiency (NMC, 2010a). The standard of proficiency is laid out in a number of competencies. These are skills and abilities which enable the student to practice safely and effectively without the need for direct supervision.

A competence standard as defined by the Equality Act (2010) is ‘an academic, medical or other standard applied for the purpose of determining whether or not a person has a particular level of competence or ability.’ (Equality Act 2010. Sch 13, para. 4(3)). Nursing and midwifery programmes should be designed in a way which ensures fitness to practice competence standards can be met, but at the same time not designed in such a way that prevents students with disabilities from meeting those standards (Equality Challenge Unit, 2015).To achieve this, Approved Educational Institutions (AEIs) are obliged to make reasonable adjustments to the way competence standards are assessed so to ensure disabled students can demonstrate how they have met them (Equality Challenge Unit, 2015). The AEI is not expected to make a reasonable adjustment to a quality standard, only the way in which they are assessed (Equality Challenge Unit, 2015).

Competencies are accumulated throughout the placements and are all expected to be met by the end of the nursing and midwifery programme (NMC, 2008b). However, there is an expectation that students will have supernumerary status throughout their programme which means students must be supervised directly or indirectly at all times (NMC, 2008b).

In order to enrol on a pre-registration programme and continue once qualified, the NMC requires students and registered staff to be in ‘good health and of good character’ so to secure safe and effective practice (NMC, 2010b). To make sure these are met, guidance documents state additional procedures are to be carried out including routine health screening and occupational health assessments (NMC, 2009) for those students who disclose a disability which may not demonstrate good health. This illustrates how the NMC has responded to recent UK disability

legislation and made efforts to address inequality within both the profession and education. But it also asserts that disclosure plays a pivotal role in the measurement of fitness to practice (Stanley et al., 2007b).

The Disability Rights Commission (DRC) (2007) applied further criticism with regards to the legal background of the medical standards. The report argues that not all the NMC requirements relate to the ability to do the job and therefore do not amount to a legitimate competence, making mental fitness likely to generate direct discrimination. They suggest that deeming a person unfit on the grounds of their disability, but simultaneously register a person with a different disability or no disability with the same qualification could measure up to direct discrimination. Furthermore the study also found that many of the stereotypes around disabled people as being unfit to practice are still prevalent within the NHS. Considering the legal requirement to meet fitness standards, the DRC's (2007) findings are significant to disabled nursing and midwifery students. Therefore it is important to investigate if similar attitudes and interpretations of fitness standards are still circulating, and if so, what influence do they have on students with a mental health label. This is especially pertinent as more students with mental ill health labels and other disabilities are choosing to study in the healthcare fields than previously (Ijiri and Kudzma, 2000; Konur, 2002; Morris and Turnbull, 2006).

2.10 Student disabilities

The World Health Organization (WHO) (2011a) estimates that 15 per cent of the global population live with a disability, which equates to more than a billion people. Residents of the UK who are included in this group are an estimated 11 million people. Due to the widening participation agenda (DfES, 2003; NHS, 2010) and equality legislation (HMSO, 2010), it can be argued that the student population may be more representative of the diverse general population than in the past. Therefore it is not surprising that the number of disabled students known to the university sector has

increased (Riddell and Weedon, 2014) year on year, and over the duration of the last five years the number has doubled within the UK (HESA, 2016a). The disability statistics from the university under investigation (The University, 2016) and a further seven studies suggest students labelled dyslexic are significantly higher in comparison to other disabilities (Konur, 2002; Morris and Turnbull, 2006; Murphy, 2009; HESA, 2016a). Tinklin et al. (2004) posit that the number of students who have disclosed a dyslexia label or have acquired such a label during their time at university has doubled. The literature tells us that this is not exclusive to the UK. For instance, Sweden (Berggren et al., 2016) and Australia (Cummings et al., 2013) have reported similarities, whereby dyslexia is the most frequent disability within higher education. In contrast, the majority of students who have a disability in the US are known to have a mental health label (Berggren et al., 2016). It is therefore comprehensible why the majority of student disability studies and discussion papers have focused predominantly on dyslexia, both within health professional programmes (Ijiri and Kudzma, 2000; Selekman, 2002; Sanderson-Mann and McCandless, 2006; White, 2007; Murphy, 2009; 2011; Evans, 2014; Howlin, 2014b) and within higher education as a whole (Madriaga, 2007; Mortimore, 2013).

However, it can be argued that the statistical data should be examined with some caution as the estimates are dependent on disclosure of students who identify with a disability label and intend to access reasonable adjustments (Selekman, 2002). Students who do not identify with the disability label or do not wish to proceed with an assessment for adjustments are excluded from this data. Despite this, Rose (2006) estimates that one in six students is covered by the legislative disability definition. The prevalence of data of disability among the student population can be attributed to a number of factors. For instance it can be argued that universities are becoming a more inclusive environment (Morris and Turnbull, 2006; Murphy, 2009) which has enabled more students to study (Equality Challenge Unit, 2010). Students may be feeling more confident and safe to disclose a disability. However, this is unknown as an equally

viable explanation is the increase of disabled students generally. Despite this, the number of students with disabilities is disproportionately low on courses which result in a professional qualification (Riddell et al., 2004). Furthermore, students with disabilities are still more likely than non-disabled peers to discontinue their higher education courses and less likely to achieve a first or upper second class degree (Department for Business Innovation and Skills, 2016). Therefore it can be argued that the need to work toward inclusivity and equality requires further development (Healey et al., 2006). To contribute, it is paramount to investigate if educators' and students' understanding of mental ill health, reasonable adjustments and NMC fitness requirements influence the successfulness of nursing and midwifery students with a mental health label.

2.10.1 Student mental health

Student mental ill health comes under the disability definition as stated in the Equality Act (HMSO, 2010) but similar to statistics of disabled students as a whole, the numbers of students diagnosed with a mental health condition is equally unknown. However, studies have revealed extensive data suggesting student mental health is on the increase (Kitzrow, 2003; Blanco et al., 2008; Mowbray et al., 2006; Equality Challenge Unit, 2010; Royal College of Psychiatrists, 2011; American College Health Association, 2015). The number of students with disabilities known to have a mental health condition has doubled from the academic year 2009/10 to 2014/15 (HESA, 2016a). It can be argued that the increase may be attributed to more people being open about experiencing mental distress than in previous generations, rather than an increase in mental ill health per se. The diagnoses involved in this study and highlighted within the literature review typically include depression, anxiety disorders, bipolar disorder, schizophrenia (Kitzrow, 2003; Hunt and Eisenberg, 2010) and post-traumatic distress disorder (PTSD). This is not an exhaustive list of mental health conditions, but is arguably relevant to this study.

Whatever the reason, evidence would suggest the prevalence of mental ill health among the student population is a cause for concern, especially if students are more likely to experience mental ill health than their non-student peers (Brown, 2016). This is a view supported by Bewick et al. (2008) who conducted an online survey of mental distress within a UK university and found that 29 per cent of undergraduates acknowledged clinical levels of psychological distress. A further study conducted by Bewick et al. (2010) also found the levels of distress did not reduce throughout the course. Another UK survey, which questioned 1093 students in both further and higher education, conducted by the NUS (2013) found 92 per cent of respondents felt they had experienced mental distress. The research also documented that a third said they had had suicidal ideation over the past year. This figure increased to 55 per cent for those who did not identify as heterosexual. Since 2010, the university under investigation has also experienced an increase in students known to have a mental health condition. The academic year 2014/2015 saw a slight reduction owing to the decrease in undergraduates as a whole. However, mental ill health still remains to be the second most frequent disability after specific learning difficulties including dyslexia (The University, 2016). Despite a slight reduction in the last reported academic year, the number of students accessing the mental health advisor has continued to rise (The University, 2016).

The majority of epidemiological studies have been conducted in the United States and the findings suggest high mental ill health among the student population and its effect on education (Mowbray et al., 2006) is not exclusive to the UK. Zivin et al. (2009) conducted an online survey of 2843 US college students and found that 15 per cent of undergraduates were considered positive for depression or anxiety disorders. The study also reported that over a two year period, students diagnosed with mental ill health increased their rates of suicidal ideation, anxiety and self-harm. Similar findings from a survey representing 302 counselling services within university settings found that 80 per cent of students were known to have

depression (Gallagher, 2009). Blanco et al. (2008) found that almost half of the students met the DSM-IV criteria for at least one mental health condition in the previous year. Also in the US, a study conducted at one university found that 15.6 per cent of undergraduates met the criteria for depression or anxiety and that 44 per cent said that their experience of mental ill health affected their academic success (Eisenberg et al., 2007). More recently the American College Health Association (2015) reported 16 per cent of undergraduates found it difficult to function due to depression in the previous 12 months and 20 per cent felt overwhelmed by anxiety.

An increase in mental ill health among the student population has been reported across the globe. For example Bayram and Bilgel (2008) from a study of Turkish university students and Nerdrum et al. (2006) from a study of Norwegian first year undergraduates found a high prevalence of mental ill health. Stallman, (2010) conducted a survey of 6479 students from two large Australian universities and found psychological distress experienced by students was significantly higher than amongst the general population. In contrast, Blanco et al. (2008) used data from a US National Epidemiological Survey to examine the prevalence of mental health labels of college students and their non-college peers. While they found mental ill health across both groups to be equal, they did find bipolar disorder to be less common among the student population.

The literature tells us little about the extent of mental health labels among students studying healthcare subjects, compared to other higher education courses and disabilities. However, Shrewsbury (2015) does acknowledge that disabilities as a whole are under-represented in medical education. There are no studies which suggest that the occurrence of mental health conditions among students studying nursing and midwifery programmes are any higher or lower than the general student population. However, research both in the UK (Cleary et al., 2012; RCN, 2013) and internationally (Ahmadi et al., 2004; Mowbray et al., 2006) have reported high numbers of nursing and midwifery students experiences of stress and mental ill health. Nursing

and midwifery students may start their education with anxiety and/or depression, eating disorders and substance use disorders (Mowbray et al., 2006; Cleary et al., 2012). Students may also experience mental distress for the first time during their nursing and midwifery education (Cleary et al., 2012; Riddell and Weedon, 2014).

2.11 Legislative responses to student mental health

Students diagnosed with long-term mental health conditions have been the focus of policy development for nearly twenty years, partially as a result of the Disability Discrimination Act (DDA) (HMSO, 1995) which played a significant role in the widening participation agenda. Unlike the Americans with Disabilities Act (ADA) of 1990, it wasn't until 2001 through the Special Educational Needs and Disability Act (SENDA) (HMSO, 2001), that the DDA was enforced within educational institutions. This amendment, now Part 4 of the DDA 1995, played a pivotal role for ensuring equality for disabled students. It drove forward the premise that universities have a responsibility to ensure disabled students can access a variety of courses and made discrimination of disabled students since September 2002 prohibited. This included the suggestion that a failure to make reasonable adjustments or treat disabled students less favourable without justification was discriminatory. Before this, higher education for disabled students was predominantly inaccessible and adjustments were dependent on the goodwill of staff (Barnes, 1991).

To be protected by the law, a student has to be considered disabled as defined by the Equality Act (HMSO, 2010). The law considers a student disabled if their disability has a long-term and substantial effect on their ability to carry out normal day-to-day activities (HMSO, 2010). Students who have a mental health diagnosis acquired from a medical professional are considered disabled within statute if they meet the above criteria. A mental health diagnosis does not automatically constitute a disability under the law unless it meets all of the criteria stated above. This means that

students who experience mental distress which is likely to last less than 12 months will not constitute a disability. However a student may for example have a Bipolar Disorder diagnosis and currently be experiencing mental wellness, but as the condition is long-term, it is considered a disability.

In addition, the Act (HMSO, 2010) places a Disability Equality Duty (DED) on Higher Education Institutions (HEIs) and regulatory bodies with the intention of eliminating disabling discrimination and promoting equality of opportunity. Since 2006, DEDs require HEIs to be proactive in making sure disabled students are treated equally. Universities, with the involvement of disabled people, students and staff are obliged to develop 'Disability Equality Schemes' every three years. Part of this is to ensure students have access to reasonable adjustments.

2.11.1 Reasonable adjustments

The concept of reasonable adjustments was introduced and made a legal requirement in the UK as part of the DDA (HMSO, 1995). This was inherited from the United States, commonly known as reasonable accommodations (Lawson, 2008). Since 1995, the law stipulated employers' obligation to make reasonable adjustments and support employees with disabilities in a fair and equitable manner. However, the DDA (HMSO, 1995) did not require reasonable adjustments to be made within education until after much pressure from campaign groups such as SKILL (National Bureau for Students with Disabilities (Riddell et al., 2007). It was not until the Special Educational Needs and Disability Act (HMSO, 2001), were reasonable adjustments expected to be provided within education. This was and still remains significant, as it places a duty on universities and practice partners to make reasonable adjustments with regards to teaching, learning and assessment if students disclose. HEIs are required to make reasonable adjustments if disabled students are at a disadvantage compared to non-disabled students (HMSO, 2010) so to ensure all students can reach their full potential. This provision is extended

further to include regulatory bodies. The NMC (2010b) state that evidence of support for disabled students in both university and placement settings are essential.

In order to obtain reasonable adjustments, students are required to disclose their disability and provide medical evidence before any assessment will commence. If the disability comes under the legislative definition, HEIs are legally obliged to assess and implement reasonable adjustments. As nursing or midwifery students, an occupational health assessment should be conducted prior to enrolment if a disability is disclosed on application. This is to ascertain the student's ability to complete the programme and identify adjustments as soon as possible.

Once a student is assessed and adjustments agreed, a Learning Support Profile (LSP) for the academic setting and Practice Placement Agreement (PPA) for clinical settings will be drawn up. The LSP will be compiled in partnership with the lecturer, student and university's disability service. The NMC (2008b) request that mentors should be informed of any individual requirements needed to be put in place prior to the student placement. In practice this means the lecturer, student and mentor should draw up a PPA for that specific placement.

The cost of such adjustments is met through non-repayable grants called Disability Support Allowances (DSAs). These assist students with the added costs that are incurred in relation to their study. During 2010/11 academic year, over £125 million was spent on additional support, an increase of £33 million since 2008/09 (Willetts, 2014). More recently, the HESA (2016b) reported 8.5 per cent of students doing their first degree access DSAs. While DSAs may be essential for students to participate in education, they have also been criticised as responding to an individualised understanding of the concept of disability (Riddell et al., 2007). The focus here is on the student, which reinforces a medical model of disability by allowing disabling barriers created by the environment, policy and attitudinal responses to continue. It can be argued that the recent changes to DSAs

may contribute to reducing a medical model approach by requesting that universities reduce the need for reasonable adjustments through making anticipatory changes.

Prior to September 2015, DSAs were solely funded by the government, but now universities are expected to take some responsibility over the cost. The government's view is that new approaches to delivering inclusive education will remove the need for non-medical support (Department for Business, Innovation and Skills, 2014). However, it is a plausible conjecture that the current changes in access to DSAs could impact on the receipt of reasonable adjustments. In the context of nursing and midwifery education, the concern is extended further due to the nursing and midwifery bursaries to be replaced with student loans planned in August 2017 (Department of Health, 2016b). Both policy developments may exacerbate the already high prevalence of mental ill health among the student population as the withdrawal of financial support and the recent economic recession may impact on student mental wellbeing (Megivern et al., 2003; Royal College of Psychiatrists, 2011).

Despite these changes, anticipatory adjustments are not a new concept as they have been part of legislation within education since 2001 (HMSO, 2001). This requires universities to be proactive in discovering and eradicating disabling barriers for students, as opposed to only responding to students following a disclosure or complaint about discriminatory practices (Lawson, 2008). Whether anticipatory or reactive adjustments, if HEIs are found to be non-compliant, a student has the right to make a claim of discrimination (HMSO, 2010) and is likely to be successful (Cummings et al., 2013).

However, the law states that adjustments deemed unreasonable are not required to be put in place. Determining what is reasonable and what is unreasonable is complex in clinical (Tee et al., 2010) and other settings (Lawson, 2008). Considerations include looking at how effective the change will be in removing the disadvantage and its disproportionate burden on the

duty-bearer when ascertaining the reasonableness of an adjustment (Lawson, 2008). This includes its practicality, cost, resources available and size of the HEI (Equality Challenge Unit, 2015) and clinical setting. Furthermore, despite concerns about watering down competence standards (Sowers and Smith, 2004; DRC, 2007), there is no legal requirement that a reasonable adjustment should be made to a competence standard (Lawson, 2008; Equality Challenge Unit, 2015).

2.12 Conclusion

To comprehend personal and institutional discourses of mental ill health within nursing and midwifery, it was considered imperative to gain an understanding of the historical milieu. The chapter's chronological description has shown how mental health has changed throughout historical periods. The discussion has been able to show its influence on historic and contemporary policy, medical categorisation and interventions. This includes the notion of confinement of mental ill health as a moral obligation, to broadening its jurisdiction to narratives about disease and medical treatment. Following a brief historical synopsis, an outline of the current issues regarding mental health has also been presented. The literature tells us that people experience mental health stigma, not helped by a media which reinforces prejudicial ideas through negative and sensationalised portrayals.

Considering the extensiveness of mental health stigma and the array of studies which suggest mental ill health is high among the student population, it is paramount that students with a mental health label are not discriminated against during their nursing and midwifery education. This is helped by ensuring disabling barriers faced are reduced by placing a duty on universities and regulatory bodies to implement anticipatory or individualised adjustments. However, despite government and regulatory anti-discriminatory policies, the literature presented in chapter three will argue that discriminatory practices are not exclusive of nursing and

midwifery education and professions. The literature suggests nursing and midwifery educators and policies are influenced by discriminatory ideas and beliefs highlighted in this chapter.

Chapter 3: Literature Review

3.1. Introduction

As demonstrated in the previous chapter, it is likely that some students on a nursing and midwifery programme will experience mental ill health prior to enrolment or during their education. Reviewing the literature has indicated that mental health stigma is still encountered by students participating in higher education courses including those of a professional nature. Adding to this, the literature is able to tell us that mental health stigma and discriminatory practices are not exclusive to academic settings but are also prevalent in clinical areas.

Following a review of the literature, this chapter will present findings of research which focus on student mental ill health and disabilities generally. As a result of an initial review, it was found that research studies regarding mental ill health and discrimination specific to nursing and midwifery education and practice was limited but will form part of this chapter. Other research studies around discrimination of mental ill health, and other disabilities within education generally and healthcare provision has been conducted and will be included in this chapter. The literature focuses on studies which illustrate attitudinal responses to mental ill health and other disabilities, the experiences of disclosure and reasonable adjustments within education and healthcare practice. As a result of this review of the literature, I will discuss these topics in detail and highlight the research gaps which contributed to developing the aim of this study and research questions, also presented. This chapter will show how more research is needed to focus on mental ill health within nursing and midwifery.

3.2 Literature Search

The literature review was approached in two stages. Firstly a literature search was conducted to explore the topic of disabled students enrolled on

nursing and midwifery programmes and other higher education courses, to make certain a range of issues could be examined. To ensure the literature search was relevant and manageable, literature published after the introduction of SENDA (2001) and some seminal pieces were accessed on relevant databases in order to isolate the research literature pertinent to the topic. These databases are listed below in relation to the topic areas of student disability and nursing and midwifery education:

- Cumulative Index to Nursing and Allied Health Literature (Cinahl)
- National Library of Medicine (Medline)
- Allied and Alternative Medicine (AMED)
- Applied Social Sciences Index and Abstracts (ASSIA)
- Internurse
- British Nursing Index (BNI)
- EBSCO
- Wiley Online Library

Search terms included disability, reasonable adjustments, fitness to practice and standards, nurse, midwife, dyslexia and clinical placement, all of which were combined in order to identify relevant literature. Searching for students with disabilities revealed studies focused predominantly around dyslexia and physical disabilities. The second stage of the review accessed the subsequent databases to allow student mental ill health literature to be incorporated (See appendix 1 for a detailed account of the literature review search strategy).

- PsycARTICLES
- PsycINFO

Relevant websites were also incorporated into the search. Literature not present in electronic format during both stages was handpicked from the university's catalogue, including books and other written text.

3.3 Health professionals' attitudes towards mental ill health

The previous chapter has illustrated how the presence of mental health stigma among the general public is both prevalent and damaging. The review of the literature suggests that some mental health professionals have a more positive response to people experiencing mental ill health. Munro and Baker (2007) conducted an attitudinal study of 140 qualified and unqualified mental health nurses. They found that qualified staff had a more positive attitude around mental ill health than unqualified staff. The authors attributed this to having a mental health nursing qualification. Similarly, Linden and Kavanagh (2011) conducted a survey, completed by 66 student mental health nurses and 121 qualified mental health nurses. The study found that community mental health practitioners demonstrated more positive attitudes compared to those working in an inpatient setting. Other mental health professionals have also endorsed a positive attitude towards patients. For instance, Kingdon et al., (2004) sent a questionnaire to members of the Royal College of Psychiatrists in the UK and found that psychiatrists' attitudes toward mental health patients were generally more positive than attitudes held by the general population.

It is a plausible conjecture that working directly with patients who experienced mental ill health contributes to a more positive outlook. However, the research suggests that negative and stereotypical attitudes about people with a mental health label are not exclusive to the general population. For instance, whilst Linden and Kavanagh (2011) found positive attitudes, they also found that mental health nurses working in inpatient settings reported similar attitudes found among the general public, including that patients with schizophrenia were dangerous and should be avoided.

Despite cultural constructions of mental ill health may differ across the globe, these findings are not exclusive to the UK. International studies have found similar attitudes towards mental ill health among nursing professionals. A Canadian study, (Clarke et al., 2007) conducted within emergency departments illustrated negative attitudes towards patients experiencing mental distress. A comparative study of attitudes around

mental ill health found that nurses from Lithuania and Italy also demonstrated negativity (Chambers et al. 2010). Two Swiss studies also found that mental health nurses had similar attitudes including the stereotypical assertions of unreliability and violence (Lauber et al., 2006) and would prefer to keep a social distance (Nordt et al., 2006). The latter study also found that between 1.5 to 5 per cent of participants disagreed with patients' rights to vote or run for office. An Italian study Magliano et al. (2004) found that 34 per of mental health nurses said that patients should not be able to vote, while only 37 per cent of nurses thought that people should be able to get married.

The literature which captures the experiences and perceptions of mental health service users are consistent with these findings. Within the general hospital environment, research has found that patients experiencing mental ill health have received poorer healthcare (Thornicroft, 2006). There has been reports that patients have felt that their concerns are not taken seriously compared to those patients with physical complaints (DRC, 2006). The Mental Health Foundation (2000) reported that 32 per cent of mental health service users felt they were discriminated against by health professionals. Thornicroft (2006) and Hamilton (2010) suggest that mental health service users perceive that the worst stigmatising behaviour has come from health services.

Students' interaction with other healthcare professionals will be experienced during their nursing and midwifery education but may not be confined to clinical placements. The most prominent and for some the first interaction with a healthcare professional will be with the general practitioner (GP) (Royal College of Psychiatrists, 2011). This may be a necessary response to wishing to receive reasonable adjustments and is eligible as medical proof of mental ill health is required. Research suggests that the request for reasonable adjustments can be in response to difficulties with studies (Berggren et al., 2016). In addition, the interactions with a GP or professionals during placement for some students could be at a time when the student is at their most vulnerable and a reliance on understanding and help will be expected (Wahl and Aroestry-Cohen, 2010).

Therefore it is a cause for concern that studies have shown mental health stigma is also prevalent among general practitioners.

The Royal College of Psychiatrists (2011) found that 44 per cent reported experiencing discrimination from GPs. Other people experiencing mental distress felt that their GP knew little about mental health conditions (Lynch, 2004; Beresford et al., 2010). Mental health service users reveal how prescribed medication is the principle response from GPs (Beresford et al., 2010). It can be argued that these studies demonstrate a potential correlation with a recent survey which reported only 15 per cent of students experiencing mental ill health told their GP (NUS, 2013).

Stigmatising attitudes have not only been directed towards patients. Prior to 2002, nurses and or midwives were unable to work in NHS settings unless they had been free from mental health treatment for two years. This suggests an assumption that mental ill health has adverse effects on nurses' or midwives' practice. This was later revoked (Department of Health, 2002) due to it being in conflict with disability discrimination law.

Despite this change in legislation, research illustrates that similar attitudes are still prevalent towards healthcare professionals who have personal experience of mental ill health. Studies have found that people with disabilities including mental ill health within nursing and midwifery are seen as patients rather than co-workers. This was reported by an NMC commissioned project which found that discussions around being an equal opportunities employer could be demonstrated by improving access to a disability service. Some people within this discussion felt that improvements were not linked to being a good employer as people with disabilities were assumed to only be clients and not employees (Gooding and Kane, 2009). The report also highlighted that qualified staff are still concerned about disclosing health needs due to the fear of discrimination and recrimination. It was reported that staff felt they need more information and guidance on what is meant by a reasonable adjustment.

The RCN (2013) found similar concerns, whereby nurses and midwives were fearful that poor absence may contribute to future decisions about their employment, or they were made to feel guilty by managers and colleagues. As a consequence, a high proportion of nursing staff choose to attend work despite feeling mentally unwell. In addition, nurses and midwives felt unable to access occupational health as they didn't feel comfortable asking their manager to make a referral. Keeping experiences of mental distress to oneself is not unique to nursing and midwifery professions as other studies have found the majority of employees in other professions have chosen not to inform their managers or colleagues (Bodman et al., 2003; Reid et al., 2013).

These studies demonstrate the prevalence of mental health stigma within healthcare. Therefore it would be of interest to find out if these negative attitudes are among nursing and midwifery educators, or if a safe and inclusive learning environment is provided, especially as it may influence a student's delivery of patient care or personal disclosure of mental ill health.

3.4 Attitudes towards mental ill health and other disabilities within education

Participating in an educational environment which provides positive support and understanding can prevent any mental health symptoms from interfering with academic performance (Megivern et al., 2003). Therefore it seems understandable that an environment able to meet the needs of all students, including those with a mental health label, would be beneficial. This ideological position has been driven by the widening participation agenda (DfES, 2003; NHS, 2010) and as a result has diversified the student population.

A safe and inclusive learning environment needs to be provided by nursing and midwifery educators through support and role modelling (Clark and Springer, 2007). Research has shown that the influence of supportive

attitudes from educators enable a positive experience for students experiencing mental ill health and other disabilities (Vickerman and Blundell (2010). Similarly Tee et al. (2010) found that encouraging attitudes from people whose role is to assess access needs have enabled students to feel more confident and able to discuss issues during placements. This may be attributed to people acknowledging that students with disabilities are able to pursue nursing and midwifery education.

In contrast, research suggests that nursing students have experienced discrimination as a result of their mental health (Schafer et al., 2011). Educators have felt uncomfortable in dealing with students who present symptoms of mental ill health (Becker et al., 2002). It is also accepted that mental ill health among the student population may extend the length of time it takes to complete the programme or affect the student's ability to complete their education (Royal College of Psychiatrists, 2011). This reflects Ijiri and Kudzma (2000) who argue that students with disabilities are more likely than non-disabled students to leave higher education before completion. However, it can be argued that this has the potential to permit academics and other university staff to incorrectly assume a person will be unsuccessful in pursuing studies (Mowbray et al., 2006).

Research suggests that assuming unsuccessful completion is based around stereotypical assertions. For instance the DRC (2007) found decisions regarding an ability to undertake a course were made prior to enrolment following a disclosure on the student's application. It was assumed that mental ill health and other disabilities was a predictor of completing the programme. In contrast research suggests acceptance and a supportive environment (Selekman, 2002) not only helps learning but reduces anxiety experienced by students (Kolanko, 2003). This suggests early departure is potentially linked to educators' attitudes, quality of teaching and not disability.

Sowers and Smith (2004) and DRC (2007) found that nursing faculty members had some concerns about the impact mental ill health and other disabilities can have on clinical standards. More recently Tee et al. (2010)

found some mentors, when first meeting a disabled student, were concerned about fitness to practice.

Other stereotypical assertions include being a health and safety risk (Wright and Eathorne, 2003; Morris and Turnbull, 2006; DRC, 2007), resulting in students being asked about the possibility of unsafe practice (Wright, 2000). Educators have also assumed students with disabilities may weaken academic standards (Mortimore, 2013) or be unable to meet nursing and midwifery competency standards. These studies illustrate how initial judgements can influence an educator's expectation of the student. Disability as a diverse concept is associated with a variety of impairments, some of which are perceived to be more incompatible with pre-registration programmes than others. While certain mental health conditions would not affect a person's ability to be fit for practice, there may be situations whereby a student's ability to learn effectively may be hindered (Cleary et al., 2012). However, Sin et al. (2007) found that mental ill health was considered to be the most incompatible disability within meeting professional practice competences.

The literature suggests that other contributory factors may influence nursing and midwifery educators' perception around the potential of students who experience mental ill health. For instance, the fitness standards and subsequent guidelines have been criticised for being unclear (Griffiths et al., 2010), vague (Stanley et al., 2007a) and disabling (DRC, 2007; Sin et al., 2007). Sin and Fong (2009) add that the fitness standards can portray disabled students and disabled registered professionals as a risk to themselves and to patients because of their impairments. The most criticism has been with regards to the 'good health and good character' requirement (NMC, 2010b) which are open to interpretation (Sin et al., 2007) and may discourage students with disabilities from applying (Gooding and Kane, 2009). It would be of interest to find out if the interpretations of the fitness standards and other university policies and guidelines are similar and if these influence students with a mental health label. It is argued that

knowledge of discriminatory attitudes will prompt discussions among educators and highlight areas for improvement.

3.5 Disclosure

As previously highlighted in chapter two, accessing reasonable adjustments or other support within higher education is immersed in the social practice of disclosure, owing to equality legislation (HMSO, 2010). The legislation allows disclosure to be situational in that it is only necessary if the student wants to be assessed for reasonable adjustments (Olney and Brockelman, 2003). However, if a student's mental ill health is considered to impact on patient safety (NMC, 2010), then there is an expectation to disclose. Despite disclosure being encouraged at application stage, studies have reported some resistance by students across various educational programmes.

Horsfall et al. (2010) and Cleary et al. (2012) suggest mental health stigma and prejudice has reduced. This may be attributed to an array of celebrity disclosures of mental ill health over the last decade, which could have had a positive influence on peoples' understanding. These include the Olympian Dame Kelly Holmes, the comedians and activists Stephen Fry and Ruby Wax and television presenter Linda Nolan to name a few. The MRC (2010) suggest these disclosures contribute to the progress of reducing stigma.

Disclosing may also be beneficial to both students (Ijiri and Kudzma, 2000; Sin and Fong, 2009) and people who have not experienced mental ill health. For example, students have been found to disclose their disability in light of the benefits it entails including access to reasonable adjustments, support (Konur, 2002; Selekman, 2002; Wray et al., 2005; Morris and Turnbull, 2006) and stigma reduction (Bos et al., 2009). Ralph (2002) also asserts disclosure can help build new relationships and contribute to the recovery process.

However, various studies have shown that a number of students still report negative attitudes and discrimination following a disclosure (Olney and Brockelman, 2003; Illingworth, 2005; Morris and Turnbull, 2006; DRC, 2007; Sin and Fong, 2009; O'Toole et al., 2011) including being perceived as placing extra demands on practice teacher's time (Furness and Gilligan, 2004; Walker et al., 2013). Research suggests that students may have disclosed in the past, but have decided to not disclose in subsequent placements as a result of experiencing discrimination following a disclosure (Olney and Brockelman, 2003; Tinklin et al., 2005; O'Toole et al., 2010) at previous placements (Ijiri and Kudzma, 2000).

The literature suggests that disclosure is much more complex. Brohan et al. (2012) in a systematic review regarding factors influencing disclosure found that people are selective and make partial or strategic disclosures. Similar findings were identified by Bos et al. (2009) who examined the disclosure decisions made by 500 mental health outpatients in a Dutch mental health service. The study was able to illustrate the decision to disclose was selective, making it context-dependent. People were open to partners and close family members about their mental health label, but were less so with others. However, The Mental Health Foundation (2001) reported that 56 per cent of people experience stigma from family members and 52 per cent from their friends, which suggests selective disclosure does not always meet expectations of support. The literature suggests that a number of dilemmas are created for students. If students felt that a nursing and midwifery environment was a positive learning environment which celebrated diversity including experiences of mental ill health, then it would enable students to trigger an assessment which could result in reasonable adjustments or other support. For this to occur, an understanding of how disclosure is encouraged or discouraged would identify any changes needed to ensure students feel safe and supported during their nursing and midwifery education.

3.6 Non-disclosure

The literature suggests that the numbers of students who disclose on their UCAS application form is low (Tee et al., 2010; Miller et al., 2009; Vickerman and Blundell, 2010). This is partly encompassed by a fear of being unsuccessful in obtaining a place on the chosen programme (Miller et al., 2009; Vickerman and Blundell, 2010). Once enrolled, studies have shown that the majority of students continue to not disclose their mental ill health to university staff (Megivern et al., 2003; Martin, 2010). This is partly attributed to a fear that it would influence their employment opportunities once their nursing or midwifery programmes were completed (Venville et al., 2014). These studies indicate students' awareness of public stigma, which suggest decisions are made so to avoid harm (Corrigan and Matthews, 2003).

Due to the lack of a physical manifestation (Matthews and Harrington, 2000) and the staff student ratio (Tinklin et al., 2005), being able to choose whether to disclose your mental ill health can be made easier (Goffman, 1963; Mullins and Preyde, 2013; Riddell and Weedon, 2014). Goffman (1963) posited that people with hidden disabilities feel coerced into 'passing' as non-disabled to circumvent social oppression. He suggested that to pass as non-disabled has 'great rewards' in that people will not be seen as different to the majority and permits a person to ensure attention is not brought to them. However non-disclosure does not always protect students from any negative outcomes as an awareness of stigma can have just as much or more detrimental effect on a student's mental wellbeing (Markowitz, 1998; Corrigan et al., 2000; Link and Phelan, 2006).

Even though Stanley et al. (2007b) reported a large majority of participants disclosed their disability within their workplace or academic setting, the literature predominantly demonstrated that non-disclosure is common among the student population. Non-disclosure has been attributed to a myriad of other factors. For instance it may be difficult for students to make

a decision about disclosure if their mental health fluctuates and its impact on education unpredictable (Mullins and Preyde, 2013). While it is common that students have a mental health diagnosis prior to enrolment (Megivern et al., 2003; Mowbray et al., 2006), mental distress may first become an issue for students during their nursing and midwifery education (Cleary et al., 2012). This correlates with Megivern et al. (2003) who found 48.6 per cent of students had their first experience of mental ill health during higher education.

Students considered to have a dyslexia label (Blankfield, 2001; Mortimore, 2013; Evans, 2014) or mental health label (Riddell et al., 2004; Tinklin et al., 2005; Stanley et al., 2007a) do not necessarily identify with the disability label (Riddell and Weedon, 2006), whether they disclose or not (Fuller et al., 2009). It can be argued that this is most likely among students with a mental health label as it is considered the most undesirable of all identities (Corrigan et al., 2000). Furthermore, Stanley et al. (2007b) found that social work, teaching and nursing students who have a mental health label described terminology as inappropriate and associated with physical disabilities, which suggests a dichotomy between disability and mental health. To add, in a qualitative study of focus groups and face-to-face interviews Olney and Brockelman (2003) found students with hidden disabilities viewed their impairment as context-dependent and variable. They also noted that in order to access reasonable adjustments, students were required to adopt a disability label or deficit model of disability, allowing for the legitimisation of medical paternalism (Shakespeare et al., 2009). It could be argued that the meaning of disability within the Equality Act 2010 (HMSO, 2010) adds to the complexity of the issue as having a mental health condition doesn't necessarily mean you are categorised in statute as disabled.

Non-disclosure among students has also been attributed to limited understanding about what a disclosure can achieve. This has been accredited to a lack of transparent information which resulted in students making their own uninformed judgements (Rose, 2006; Goode, 2007). In contrast, Venville et al. (2014) found that the majority of students within the

study preferred not to disclose, even when knowledge about the benefits were present. As a consequence, the lack of support or inappropriate support may create a barrier to learning (Manthorpe and Stanley, 1999; Wray et al., 2005; Morris and Turnbull, 2006). However, the issue around information is made more complex in nursing and midwifery education as students are expected to be in 'good health' (NMC, 2010b). The DRC (2007) posited the term 'good health' may deter potential students from applying or disclosing as mental ill health could be deemed incompatible with 'good health'. Similarly, Griffiths et al. (2010) argues that confusion may arise about whether good health and mental health are considered compatible. This potentially has an influence on non-disclosure, due to a fear of not being accepted onto the course.

Despite being able to avoid the harmful consequences of direct discrimination (Goffman, 1963), the requirement to disclose asserts a presupposition that the student is able to recognise when their mental health is being affected (Mowbray et al., 2006). If a student is aware, refraining from informing people about an aspect of self suggests the practice of keeping a secret (Jacklin, 2011). Therefore it can be argued that having a hidden disability places the responsibility of choosing when, how and to whom to disclose, which may become all-consuming to the individual (Goffman, 1963). The less likelihood of disclosing a mental health label, the more likely the student perceives self to be alone. As a result, the student may experience negative effects including less support than needed (Pachankis, 2007), which may exacerbate mental ill health (Pachankis, 2007; Vogel and Armstrong, 2010), potentially resulting in poor academic outcomes (Kitzrow, 2003; Martin, 2010; Mullins and Preyde, 2013). This also has the potential to impact on the wider student group if the individual's mental distress is having a negative effect on teaching or divert students from learning (Cleary and Horsfall, 2010).

The literature suggests that disclosing on a nursing and midwifery programme is a complex decision which could result in experiencing mental health stigma or a fear being solely judged on their mental health. However, the literature around disclosure and mental ill health during nursing and

midwifery education is limited. A reluctance to disclose mental ill health has been predominantly found in research studies where respondents have been qualified members of staff (DRC, 2007). Other student focused studies within nursing and midwifery or other courses have mainly examined the experiences and perceptions of students with learning or physical disabilities. For instance, Tee et al.'s (2010) found an increase in disclosure during students' third year of nursing, thought to relate to the increased demands and expectations in practice.

It is clear that students do not disclose for a number of reasons and so do not get the support they require. By reducing the stigma, it may encourage more students to disclose. Therefore it is important to not only find out if similar findings are found within nursing and midwifery education, but to identify how stigma can be reduced in order to enable students to disclose and access reasonable adjustments.

3.7 Students' experiences of reasonable adjustments

Equality legislation (HMSO, 2010) clearly states universities have a duty to make reasonable adjustments if students disclose a long-term disability which has a substantial effect and places them at a disadvantage compared to non-disabled students. This duty has been part of legislation since 2002, and as a result has seen a number of research projects which have explored the experiences of students with disabilities and reasonable adjustments on general degree courses (Sanderson-Mann and McCandless, 2006; Vickerman and Blundell, 2010), social work programmes (Sapey et al., 2004; Wray et al., 2005) and healthcare programmes (Selekman, 2002; Illingworth, 2005; Sanderson-Mann and McCandless, 2006; Morris and Turnbull, 2006; 2007; Royal College of Nursing, 2007; White, 2007; Tee et al., 2010; Griffith et al., 2010; Storr et al., 2011).

The literature has demonstrated how reasonable adjustments can be open to interpretation (Shrewsbury, 2015) as some educators have deemed them

as giving an unfair advantage to non-disabled students (Riddell and Weedon, 2006; Riddell et al., 2007; Vickerman and Blundell, 2010; Hargreaves et al., 2013). Despite this, research has highlighted a number of factors which may contribute to students experiencing disadvantage. For instance students have reported difficulties with concentration (Sanderson-Mann and McCandless, 2006), a decline in academic performance (Megivern et al. 2003), social isolation (Riddell et al., 2004), not enough time in examinations or short deadlines for work (Riddell and Weedon, 2006) and patient care being disorganised (Selekman, 2002).

Therefore the identification of mental ill health presents an opportunity for educators to intervene with the intention of acquiring a positive outcome (Cleary et al., 2012). This may result from a student's disclosure in order to gain access to adjustments or as a last resort due to potential academic failure (Venville's et al., 2014). However evidence would suggest that students still experience ineffective support or find the system of accessing adjustments complicated (Olney and Brockelman, 2010).

It can be argued that requesting a disclosure at application stage of a university course demonstrates the university's anticipation of disabled students which may require an assessment, potentially resulting in reasonable adjustments. However, Vickerman and Blundell (2010) reported just less than half of students who disclosed on their application form had been contacted by the university prior to enrolment. The study also found that only 36 per cent of students who were contacted, found the process helpful.

Whether students disclose on their application or not, research suggests that students do not necessarily know what adjustments consist of or had no support in clinical placement (Murphy, 2011). Miller et al. (2009) reported that despite nearly half of the medical students who identified as disabled experienced challenges during their studies, only one third had sought support.

If students were assessed for reasonable adjustments, Fuller et al. (2004) found that 11 per cent of students asserted their disability assessment did not meet their needs. Once programmes have begun and reasonable adjustments have been agreed, students have reported difficulty in gaining consistency of adjustments. As a result, students have had to put in additional effort to ensure they are implemented (Holloway, 2001; Goode, 2007) which could exacerbate a student's mental ill health, despite Tee et al., (2010) assertion that academic adjustments are quite straightforward. One student felt like it was a constant battle to getting reasonable adjustments implemented, even though they were documented (Tinklin et al., 2005). This is not exclusive to the UK as students with disabilities in Australia have also experienced inconsistency in the implementation of adjustments (Cummings et al., 2013).

To ensure clinical placements are successful for students who have reasonable adjustments, regular communication between academic and clinical educators is paramount (Selekman, 2002). This is to make sure everyone is clear about their role in ensuring students are able to reach their full potential. However, research suggests that part of the difficulties experienced by students on placement is the university and placement partners have failed to communicate about the required adjustments (DRC, 2007). The DRC (2007) recognised that a student's reluctance to disclose their disability label while on placement have contributed to this lack of communication.

As reasonable adjustments have been reported to be essential for students during clinical placements (Cook et al., 2012) it is paramount educators have a good understanding and willingness to implement them. The successfulness of implementation will be dependent on the universities established systems both within the academic and clinical setting. By enhancing educators understanding of reasonable adjustments specific for students who have a mental health label, it is argued that more appropriate adjustments will be in place.

3.8 Conclusion

Recent literature suggests that the topics of disclosure and reasonable adjustments have been widely researched, predominantly in small scale studies. It can also be argued that there is a commitment to develop an inclusive environment within higher education and the NHS as disability equality has become the vernacular of contemporary educational policies. However the introduction of equality legislation and policy does not necessarily give assurance of equality within higher education. On the contrary, there is a vast amount of research which suggests that disabled students still experience discriminatory attitudes and practices within higher education.

Barriers commonly found among disabled students include the decision to disclose or not. The literature has shown that disclosure is not only influenced by a fear of but actual experiences of stigma and discrimination. It can be argued that making a disclosure may be a dilemma for some as universities are only expected to assess and implement reasonable adjustments if a disclosure of mental ill health is made. However research has shown that disclosure does not always trigger an assessment of reasonable adjustments or once assessed, adjustments are not put in place.

Even though mental health conditions are covered under the Equality Act's definition of disability (HMSO, 2010) the focus of research predominantly acknowledges the experiences of students with physical or learning disabilities. However, the samples of those students with a mental health label within these studies have been minimal in comparison to other disabilities. This may be owing to the higher ratio of students with learning disabilities, or disclosing learning or physical disabilities are more likely to be disclosed than mental ill health. Despite the widely reported prevalence of student mental ill health and a commitment from higher educational institutions, regulatory bodies and government policies to challenge mental

health stigma, the literature suggests stigma has not reduced and discrimination experienced by students still prevails.

Research around disabling barriers experienced by nursing and midwifery students has reported homogeneous findings, but similarly the focus has been on learning and physical disabilities. The exploration of student mental health within nursing and midwifery education has been limited. The paucity is worrying considering the current prevalence and reported growth amongst the student population. Bos et al. (2009) posit this could be as a result of people experiencing mental ill health, are more likely not to participate in research. Considering the literature on mental health stigma and decisions about disclosure, this is possible. But it also suggests an urgent review of educators understanding of student mental health and inclusive practices within nursing and midwifery (Tee et al., 2010).

The debate on students with a mental health label on a nursing or midwifery pre-registration programme, aiming to meet fitness to practice standard seems limited. Whilst disability is widely researched both within the context of society as a whole and more specifically within a university setting, the analysis of the literature revealed that reasonable adjustments in practice settings and student mental health was an under explored topic among discourse studies (Grue, 2013).

Previous research has explored lived experiences of students but not why these experiences happen. When considering the stigma attached to mental ill health (chapter two) it is essential that research is undertaken exploring the reasons and how they can be addressed. This study will do this through a critical discourse analysis methodology as no previous studies could be found using this approach. Chapter four will now explore my philosophical stance as a researcher and how knowledge around mental ill health is constructed. This will be followed by an explanation of the methodology chosen to address the research questions.

Chapter 4: Philosophical and methodological frameworks

4.1 Introduction

The previous chapter explored the array of pertinent literature regarding mental ill health amongst the student population and how the nursing profession and HEIs respond, with further focus on nursing and midwifery education. The literature review enabled some possible areas for research to be explored further. However before such decisions were finalised, an understanding of my philosophical position was required so to ensure a homogeneous research design (Mason, 2002; Koro-Ljungberg, 2008 and Lincoln et al., 2011). I will justify the ontological (what exists) and epistemological (our thoughts about what exists) position of critical realism in relation to mental ill health. This will be followed by a discussion on the methodological approach of critical discourse analysis and how the research questions were established from the wider research ideas.

4.2 Ontology and Epistemology

Critical realism is a relatively new approach largely associated with Bhaskar (2008), Archer (1995) and Sayer (2000). The philosophical approach has been adopted by some scholars who specialise in mental ill health studies and other disabilities (Williams, 1999; Wainwright and Forbes, 2000; Busfield, 2001; Danermark, 2001; Shakespeare, 2014; Pilgrim, 2015). This chapter will begin with a discussion on the aspects of critical realism, followed by my philosophical journey, critically illustrated in conjunction with Clare's (1980) four orientations of mental ill health and psychiatry along with the social (Oliver, 1990), and interactional models of disability (Shakespeare, 2014). By using these models, I will illustrate how mental ill health is considered ontologically from various philosophical positions. This has enabled me to consider ontologically if I believe mental ill health is assumed to have one objective truth (Pilgrim, 2015), or if what we perceive to be factual is based on multiple interpretations. Epistemologically,

clarification on whether knowledge is presented as authoritative and an objective characterisation of reality or knowledge as changeable and relative to opposing interpretations, have also been examined. This exploration initiated an advantageous as well as challenging journey which opened up innumerable paths, leading me to view mental health from a critical realist position.

4.3 Critical realism

Clare's (1980) 'medical model' of mental ill health incorporates both a realist and social constructionist position. This is not to be confused with the medical model of disability (Oliver, 1990), but corresponds to the 'stress-vulnerability' model (Zubin and Spring, 1977) which explores the causes of mental ill health. The 'stress-vulnerability' model sets out three interactive elements: biological, stress and protective factors, all of which impact on the occurrence of a mental health condition. Biological factors are thought to influence a person's vulnerability and vary depending on the individual's genetic and early biological factors including prenatal illnesses or other early life experiences. Zubin and Spring (1977) argue that vulnerability is a relatively permanent trait, indicating its residence within the individual rather than external (Ingram and Luxton, 2005).

Similar to Clare's (1980) 'medical model', the 'stress-vulnerability' model not only takes into account the person's biology, but also recognise a person's vulnerability is not sufficient on its own to cause mental ill health, but necessitates a combination with psychosocial stresses, also dependent on the person's perception of stress (Ingram and Luxton, 2005). Stress is associated with life experiences, challenges we face and our ability to manage adversity. It is suggested that stress can exacerbate biological vulnerability, symptoms and decrease recovery. In order to reduce the likelihood of experiencing mental ill health and aid recovery, the model advocates protective factors such as taking medication, avoiding drugs and

alcohol, utilising coping mechanisms including seeking positive support networks and participating in purposeful activities.

These models accepts a social constructionist epistemology in that knowledge about mental ill health is socially created, but recognises what we call mental ill health has a realist ontology and independent of our knowledge of it, which corresponds to a critical realist paradigm (Archer, 1995; Bhaskar, 2008). Despite qualitative research conventionally adopting constructionist ontology (Bryman, 2012), critical realism is considered the most appropriate philosophical position for both the research topic and design as justified further below. Ontologically, critical realism asserts three presuppositions about the social world; intransitivity, transfactuality and stratification.

4.3.1 Transitive and intransitive knowledge

Critical realism distinguishes between two dimensions of knowledge; transitive and intransitive knowledge. Intransitive knowledge is represented by the material and social world, which exists independently whether we know of it or not (Bhaskar, 2008), whereas transitive knowledge is fallible and socially produced (Bhaskar, 2008; Sayer, 2000). This suggests that reality is not socially constructed but theories, paradigms and models about reality and how we investigate them are shaped by social forces over time (Bhaskar, 2008).

A critical realist would acknowledge people experience for example what used to be referred to as manic depression, but as theories change and transform over time in the transitive dimension, manic depression becomes bipolar disorder, but the thing being referenced is still a real entity or object of scientific knowledge and therefore intransitive. Therefore critical realism values the emergence of social and historical conditions with social constructionism. However, it does not accept the conflation of ontology with epistemology, whereby bipolar disorder is reduced to what we know about

it, rather than what constitutes it, which Bhaskar, (2008) calls the 'epistemic fallacy'. It may also include aspects about mental health that is independent of our knowledge (Bhaskar, 2008). For instance there may be students within the study that have a mental health label or experience symptoms associated with a certain mental health label but may be reticent about sharing this, making it unknown. Critical realism allows the research to explore how discourse has impacted on reality like mental ill health and also how material reality has impacted on discourse, which has generally been ignored in social constructionist research (Willig, 1999).

4.3.2 Transfactuality

Transfactuality refers to material and social mechanisms which are constant and invariable (Archer, 1998). While it is accepted that discourses around mental health have changed throughout the centuries (Foucault, 1988), Archer (1998) argues that change is very slow. This she refers to as morphogenesis (Archer, 1995). This allows the research to consider discourses utilised by participants, regulatory bodies and higher education institutions to be somewhat enduring and remain constant for a lengthy period but not immutable.

4.3.3 Stratification

Finally, Bhaskar's (2008) stratified reality argues for a greater depth to the social and natural world and partitions it into three domains of reality: the real, actual and empirical. The real domain, which can't be experienced, hosts the underlying mechanisms and structures of what exists regardless of whether we experience it or not or have knowledge of it (Sayer, 2000).

Discourse as well as society and power, resides in the real domain, which has allowed the study to explore discourses used by students, lecturers and mentors and attempted to make sense of the generative mechanisms which they operate from and cause events to happen. They exist and act

independently of human activity, whether we as social agents or society as a whole know about them or not (Bhaskar, 2008). Language used by an individual is not unique to them but will be drawn from the group's repertoire (Cameron, 2002). These will be limited range of gathered terms (Potter and Wetherell, 1987), out of social voices we already have at our disposal (Lemke, 1995). While discourses may be co-constructed by people, language, discourse and other social structures which created them came before us now and therefore are acknowledged as acting independently and before us (Sayer, 2000). This includes non-discursive factors like the power of institutions (Sims-Schouten et al., 2007), the physical space of the university and placement settings (Parker, 1992) and social structures (Willig, 1999), all of which influence discursive practices, people's endeavours and comprehensions.

Below the real domain, Bhaskar (2008) refers to the actual domain which signifies the patterns of events, experienced or not, but caused by the powers of generative mechanisms when activated and produce change (Fairclough et al., 2004). Society, power and discourse are accepted as real entities or objects of knowledge as they are considered to have generative mechanisms and cause events to happen. The empirical domain embraces what we experience (directly or indirectly), our perceptions and observed outcomes and has an essential relationship with the other domains and therefore unable to exist independently (Sayer, 2000; Danermark, 2001; Bhaskar, 2008). The approach allows this research to explore the experiences of students, tutors and mentors, while discovering the generative mechanisms which produce the experience and therefore acquire useable knowledge.

Choosing a critical realist position was a result of examining other philosophical positions including realism and social constructionism. Below I will present a discussion on my critical thinking around these concepts and justify the adoption of critical realism

4.4 A critique of realism

Clare's (1980) 'organic orientation' or biological approach reflects a realist ontology whereby mental ill health has an objective truth and obtains a physical pathology which may or may not be discovered. The emphasis stems from a positivist position in that the causes are considered genetic, biochemical, physiological and neuropsychological. Historically, mental ill health has evolved from a realist ontology whereby descriptions of mental health conditions are conceived as existing independently of ourselves (Searle, 1995), stem from objective facts, have causal powers and are consequently inclined to be accepted as reliable. This model, grounded on reducing mental health to biology (Yardley, 1997a, Pilgrim, 2015), whereby both signs and symptoms are considered to be representations of naturalism, best explains mental ill health exclusively by objective physicality. Although symptoms rather than signs are depended upon by the social practice of psychiatry, they are legitimised by how individuals interpret and communicate their own experiences (Rovinelli Heller and Gitterman, 2011; Pilgrim, 2015). This makes the objectification of mental ill health scientifically indefensible (Pilgrim, 2015), a position illustrated in the seminal work of Thomas Szasz (2010), an American professor of psychiatry.

Szasz's perspective on mental ill health is far from the organic model of mental health. He objected to the concept of mental illness as it implied some form of physical illness. Szasz (2010) argued that those professionals who recognise the symptoms verbalised by patients as a sign of brain disease excluded any links with social factors. He considered any psychiatrist who adopted such an approach demonstrated coercive practices through lawful involuntary detention (Pilgrim and Rogers, 2003). Szasz suggested that medicalising and discrediting a person's difficulty of life illustrated psychiatry's need for power (Szasz, 1973) and championed the concept that a person's reality was independent from psychiatry's notion of normalcy.

In contrast, authors such as Baker and Menken (2001) continue to take a biological view and strongly argue that mental illnesses should be abandoned and replaced with 'brain illnesses'. This approach adopts a Humean theory of causality which assumes what we observe is a constant conjunction of events; a repeated experience when event A occurs, event B will follow (Elder-Vass, 2010). Here, what is considered as naïve realism, accepts explanations are dependent on observable and measurable regularities and repeated occurrences (Gray, 2009). This suggests that the same cause and effect will apply everywhere (Bhaskar, 2008). For instance, it is widely accepted that depression is caused by neurotransmitter system functioning and can considerably influence a person's susceptibility to a range of physical illnesses (Pilgrim, 2015). It can be argued that it is much more complex as the knowledge we have of neurotransmitters is reduced to reality and therefore is confused with what we call reality, a position Bhaskar (2008) calls the 'epistemic fallacy'.

Adopting a naïve realist position, this research would assume mental ill health is linked with essential characteristics (Smith, 2009). For instance biological causation will have an effect on the experience of bipolar disorder, but the student's psychology, knowledge and experience are not counted as significant (Abberley, 1992). A realist research design would also strive to produce objective knowledge of naturally occurring phenomena and secure a 'true' instance of reality. This presupposes social objects such as people and processes including discourse (Fairclough, 1995) irrelevant (Sayer, 2011) as they would be viewed as having no causal powers.

It can be argued that adopting a realist research also asserts mental ill health can be systematically measured via value-free experimentation as values are recognised as incommensurable. However, it can be argued that researchers as social beings are biased and influenced by scientific and medical discourse, presenting a version of reality situated historically and dissimilar to another observer (Foucault, 1988; Bhaskar, 2008), making knowledge a social product (Sayer, 1992). This corresponds to the medical

model of disability, now part of the vernacular of disability research (Smith, 2009). The model equates disability to biological factors, similar to mental ill health, whereby the emphasis is on the individual's impairment and limitations of their bodies. Criticisms regarding this approach to disability research include Abberley (1992) who argued that the Office of Population Censuses and Surveys (OPCS) survey reinforced a 'personal tragedy' model of disability, which corresponds with Oliver (1990). He suggests the approach creates an inaccurate interpretation of disability, which is now widely accepted as discriminatory and oppressive. Finally, the power relationship between researcher and researched in a realist research design is argued to reinforce social inequalities between people with disabilities and non-disabled people (Danieli and Woodhams, 2005). For instance, the research topic and how it is being collected is decided by the researcher. Furthermore the research design allows the way in which it is being interpreted to reside with the researcher rather than relying on the specialist knowledge of disabled people (Oliver, 1992).

Despite much criticism of a realist position, there are some advantages. I would argue knowledge acquired by a realist design which accepts an existence of the real is generalisable, rather than knowledge acquired through socially constructed meaning, can be beneficial to the individual experiencing mental distress. It is recognised that some people need hard evidence about the consequences of their illness (Williams, 1999; Vehmas and Makela, 2008; Beresford et al., 2010), whether the evidence is fallible or not. Furthermore, despite some relief for depression from placebo medication (Kirsch et al., 2002), a socially produced representation with remedial characteristics, there are other non-placebo treatments which have been known to provide relief. For example Electroconvulsive Therapy (ECT) for depression or certain pharmaceuticals which can reduce hallucinations (Rogers and Pilgrim, 2010), indicate knowledge acquired through realist research.

4.5 A critique of social constructionism

Whilst I accept mental ill health has features which correspond with realist ontology, like Oliver's (1990) social model of disability and Clare's (1980) 'socio-therapeutic' approach, I am unable to exclude psychological and sociological aspects which contribute to the aetiology of mental ill health. Both these approaches focus on the person's social position, and the inadequacy of support within society. These correspond to a social constructionist paradigm, a term introduced by Berger and Luckmann's (1966) in his seminal work, 'The social construction of reality'. Social constructionism was my initial philosophical position which emanates from my career within the disability field, dominantly underpinned by the social model of disability. I shared the belief that multiple definitions and interpretations of mental ill health are historical (Foucault, 1988) and are an interaction between people and groups in a social system and once habitualised, become institutionalised (Berger and Luckmann, 1966). However, the in-depth examination of mental health as part of this study made me question my previous philosophical assertions, which will be explored further below.

Social constructionism challenges traditional knowledge founded upon objectivity and posits truth as relative to and created by human interactions (Berger and Luckmann, 1966) and discourse (Foucault, 1989). The term 'discourse' is defined differently depending on theoretical preferences. It was first documented by Foucault (1989) who defined discourse as a system of representation through language to form discursive formations. He argued that knowledge is created through discourse and is a joint production within a particular historical time and culture. Foucault's definition of discourse focuses on what statements are made rather than how they are made (Elder-Vass, 2010), a position not conducive to this study as the focus is on how the discursive practices within the discourse are made.

Fairclough (1995, p.14) adds that *'a discourse is a way of signifying a particular domain of social practice from a particular perspective'*. For example, both medical and biological discourses within mental ill health are particular discourses which are dominant (Rogers and Pilgrim, 2003; Busfield, 2001; Beresford et al., 2010), normative and have contributed heavily to the practices of psychiatry and pharmacy (Pilgrim, 2015). Other inconspicuous discourses, like the social model of disability, focus on the deficiencies in society rather than the focus being on the individual (Oliver, 1990).

This philosophical approach does not refute reality's independence of human beings and discourse, but suggests we have beliefs about our versions of reality and therefore cannot be appraised against reality (Burr, 2003). This suggests the examination of the causes of mental ill health is an impossible task as they go beyond our ability to explore, which is why some mental health scholars assert this exploration should be excluded from mental health research (Pilgrim, 2015).

Some scholars posit mental ill health as a construction of modern medicine. For example, Laing (2010) suggested auditory hallucinations can be experienced by every person, rather than solely people with a psychiatric condition. Auditory hallucinations are common for people who have experienced some form of abuse (Leuder and Thomas, 2000) or traumatic event (Morrison, 1998), which refutes mental ill health stemming from a brain disorder, but places mental ill health in the social domain. Therefore social constructionism posits no objective truth that is waiting to be discovered, but truth is relative to and created by human interactions (Berger and Luckmann, 1966). It can be argued that researchers influenced by scientific and medical discourse, which presents a version of reality dissimilar to another observer from a different historical time, makes research a social product (Sayer, 2000).

As social constructionism asserts the presence of multiple realities constructed by discourse and can be context-specific (Burr, 2003), the researcher and researched co-construct meaning (Holstein and Gubrium, 1995; Kvale, 1996; Mertens et al., 2011). Foucault (1990) also suggests knowledge is inextricably related to power in that it is created and perpetuated by those who have power and the means to communicate; i.e. the researcher. But he also suggests power is involved in the creation and use of knowledge.

Both suggest meaning is not discovered but constructed by different people in different ways in different situations (Crotty, 1998; Turner, 1995). For example, homosexuality up until 1980 was incorporated in the American's Psychiatric classification system, Diagnostic and Statistical manual of mental disorders, third edition (Fawcett and Karban, 2005). While homosexuality does not equate to a mental disorder in many countries today, some still view it as an illness even within the same countries which celebrate it. Consequently the conception of mental ill health is inescapably connected to the social context, cultural history, social positioning of people (Shotter and Gergen, 1989; Houston, 2001) and social processes (Burr, 2003), but is not simply from the reasoning of a single person but collaborating interpretations by multiple people (Miranda and Saunders, 2003).

Within the context of nurse and midwifery education, legislation reinforces the premise that students with a mental health label may receive reasonable adjustments to study and register as a nurse (NMC, 2010b). On the contrary, mental health nursing discourse provides an alternative view where people with a mental health label require treatment and care. This corresponds to Billig (1997) who argues that the same person can use conflicting repertoires within the same situation or conversation.

Social constructionists assert the person as discursively constructed through language, which suggests a person's behaviour and experience is

altered by discourses (Burr, 2003). Since language is social and cultural, it then posits that our perception of reality is socially and culturally constructed. Access to various discourses asserts meaning is discursively constructed as we talk and reinvent meaning over time (Foucault, 1989) including how we experience and understand illness (Conrad and Barker, 2010). Adopting social constructionism is problematic in that any view is defendable and that no view is preferable. Rorty (1979) goes further and suggests there is no transcendental position as there is nothing to say about what is out there. He postulates that no descriptions are closer to reality than others. Fairclough (2005) argues that certain extreme positions of social constructionism should be rejected as the causal powers of discourse is absent from this ontological framework. However, Gergen (2001) acknowledges the misunderstandings of social constructionism and in particular relativist ontology depicts its position as denying the existence of a reality beyond discourse. On the contrary, he asserts that discourses are divorced from the world of materiality (Gergen, 1999).

Critical realists suggest social constructionism presents what Bhaskar (2008) calls the 'linguistic fallacy' where ontology is reduced to discourses only and excludes reality beyond discourse. This mirrors the social model of disability (Oliver, 1990) which relinquishes any dialogue of impairment, functional limitation and knowledge created by the medical profession. While social constructionists consider discourse is paramount in constructing the social world (Nikander, 2008), the position disengages and excludes references to aspects like embodiment and power, which may not be experienced through language but is connected to its various textual elements (Hook, 2001).

Parker's (1992) definition, which fits comfortably with the critical realist position, defines discourse as a set of statements that bring together social objects into being. Parker (1992) suggests looking beyond the individual when attempting to understand the meaning within language. He asserts that discourses do not describe the world, but categorise it (Parker, 1992)

and produces a particular version of events (Burr, 2003) known as discursive practices which make and remake constructs as people talk. Discourses are shaped by the potential and restrictions of the material and social world; both viewed as ontological, meaning they are independent of thought, but have a relationship with discursive practices (Sayer, 2000). This is not a static process but constantly changing over time or with a single human interaction (Taylor, 2001) irrespective of what people think (Sayer, 2011).

A further difficulty adopting only a social constructionist position of mental ill health is its inability to consider the social world outside of people's perceptions and understandings. As a result it underrates how the body engages with the knowing person (Barnes, 2012), suggesting a consolidation of ontology and epistemology. Busfield (2001) adds that its sociological foundation creates a barrier with doctors, patients and families who consider it to exclude the actuality of pain and suffering or that the physiological aspect of mental health is socially generated (Williams, 1999; Pilgrim, 2015). Horwitz (2002) also considers the approach as limiting because while the concept of mental illness is being socially constructed, the natural reality of what is being constructed is still present.

4.6 Methodological framework

A methodology is the theoretical underpinnings and analysis of the methods used within research and is expected to be consistent with the philosophical position of the researcher and beneficial (Mason, 2002; Alvesson and Sköldberg, 2009). It was important to ensure the research was driven by the research questions (see 1.1) and not by the methodological framework (O'Leary, 2014).

4.6.1 Emancipatory disability research

Choosing the most appropriate methodology was not only fundamental to the research design, but also to my theoretical underpinnings (Mertens, 2005) as a disabled researcher. Historically disability research has predominantly been conducted by non-disabled people whilst people with disabilities have been the object of research (Oliver, 1992; Mertens et al., 2011), thus creating additional avenues of exploitation rather than liberation (Barnes and Mercer, 1997). More recent disability research includes social influences rather than solely exploring pathological aspects, but Oliver (1992) argues this does not go far enough as disabled people are still objects of research and asserts:

> *"...disillusion with existing paradigms has raised the issue of developing an alternative, emancipatory approach in order to make disability research more relevant to the lives of disabled people and more influential in improving their material circumstances"* (Oliver, 1996, p. 141).

He proposed a new approach; the emancipatory research paradigm, developed from critical theory (Oliver, 1992). The main features of which include a focus on exposing and changing disabling barriers and enabling people to take more control over their lives (Oliver, 1992; Stone and Priestley, 1996). A disability research project which does not aim for the emancipation of disabled people is viewed disapprovingly as it would be accused of generating knowledge which preserves oppressive discourses and practices (Danielli and Woodhams, 2005). Therefore in order to conduct an emancipatory study, I reflected on methodological approaches and data collection methods which would further the interests of disabled people (Johnson, 2009). At the same time, I was aware that this approach, while liberating one group, may at the same time oppress another (Seale, 2004).

A pursuit in discourse methodologies concordant with the emancipatory research paradigm was examined and led me to critical discourse analysis. Before such a methodology is explained, I will briefly give a rationale for other appropriate methodological approaches appraised but later superseded by analysing discourse. This will be followed by an introduction to key concepts such as language and power, accompanied by other discourse analytical approaches considered but discarded.

4.6.2 Methodologies considered but discarded

Having applied grounded theory approach in previous studies, I could see how a similar path could have been emulated, due to the limited array of literature on disability discourse, especially within the clinical setting. The approach, developed by Glaser and Strauss (1967), concentrates on interpreting meaning through a systematic data collection process, with the intension of building a theory (Corbin and Strauss, 2008). Through theoretical sampling, which determines where the next data collection is sourced, would have enabled me to identify the experiences of nursing and midwifery students and build theoretical knowledge from the ground up. To achieve this, the researcher is required to suspend their a priori knowledge or have limited knowledge of the subject area so to have a 'fresh gaze' (Glaser and Strauss, 1967). This is discordant with the emancipatory research paradigm whereby the social model of disability is utilised as a heuristic device in order to identify disabling barriers (Barnes, 2003), which should be changed.

Phenomenology was also explored as it is interested in collecting people's subjective lived experiences, usually via in-depth interviewing. However it was evident during the review of the literature that analysing peoples' lived experiences of disability had been previously undertaken (Holloway, 2001; Stanley et al., 2007b; Vickerman and Blundell, 2010). These studies focus on identifying the relationship between the world and the experiences and

perceptions of the world. Contrary to a critical realist position, phenomenology investigates descriptions of experiences as simple reflections of the participant (Kvale, 1983). This allows for society to be viewed a-historically, (Bronner, 2011), while excluding social ontology including power, institutions and other social structures. Also I wanted to go deeper and examine how discourses shape these experiences rather than just describe them.

4.6.3 Approaches to discourse analysis

The analysis of discourse is presented through a variety of disciplines, but predominantly through discourse analysis, a methodology, which too has varying approaches, depending on different theoretical positions. Though discourse analysis is an umbrella term (Cameron, 2002), all approaches agree that language isn't neutral, transparent and essentialist, but is historical, cultural and links with social relations (Parker, 1992; Wodak, 1996; van Dijk 1998; Reisigl and Wodak, 2009).

Discourse analysis is the study of language in use, whereby meaning is created in and through text and talk. Discourse analysts are interested in how human interaction, predominantly conducted through conversation, purposefully communicates in particular ways and context (Wooffitt, 2005). However this doesn't exclude other forms of text including written and visual text which can be explored for meaning. Analysts look for recurrent patterns in how text and talk are organised and how social practices occur, constructed and reproduced.

4.6.4 Critical discourse analysis

The theoretical frameworks that set down the intent, motivation and expectation for this research (Mackenzie and Knipe, 2009) led to critical discourse analysis (CDA), an approach that has an overall aim of

abolishing oppression (van Dijk, 2001; Reisigl and Wodak, 2009). My philosophical position, the concepts of power, ideology and critique (Reisigl and Wodak, 2009) and principles of CDA played an influential part in deciding the methodological framework, all of which will be explored below. Not only are the eight principles illustrated in table 1 below, the most cited, but they can be linked to the philosophical and emancipatory approaches adopted in this study. These will be discussed in conjunction with the research topic.

Principle 1 – Address social problems
CDA is concerned with and motivated by addressing social problems such as dominance and inequality (Wodak, 2006). It is believed that the concepts of mental ill health, reasonable adjustments and fitness to practice requirements will be better understood through the examination of discourse and their relationship to dominance and inequality. It focuses on language associated with these concepts and linguistic characteristics of social and cultural processes and structures, so to present power relations both obvious and obscured (Fairclough and Wodak, 1997; Wodak, 2006).
Principle 2 – Power relations are discursive
CDA presents an analysis of linguistic forms and how they influence the social relations of power, are utilized and negotiated in and through discourse (Fairclough and Wodak, 1997). The study illustrated the 'power in' and 'power over' discourse (Wodak, 1996). I explored who had access to what discourse and information and how power relations between educators and students were re/produced through discourse.
Principle 3 – Discourse constitutes society and culture
In practice, this means that discourse contributes to shaping and maintaining society and culture and that society and culture shapes discourse (Fairclough and Wodak, 1997). Society and culture therefore are dialectically connected to discourse in a way that allows the language used by educators and students to re/produce or transform the practices and social structures within the educational setting.
Principle 4 – Discourse does ideological work
Ideological work can be both oppressive and liberating (Burr, 2003), possibly at the same time for different people. This principle suggests ideologies (organised

set of beliefs) are produced through discourse (Fairclough and Wodak, 1997) and reproduce unequal relations of power, domination and exploitation (Wodak, 1996). Analysing ideology within text needs to explore linguistic features on the surface and how they are interpreted and received by participants, but also what is not expressed indirectly by suggestion or implying (Cameron, 2002). For example I explored how educative practices and assertions were influenced by attitudes and beliefs with regards to student mental health and adjustments.

Principle 5 – Discourse is historical

Discourse is not produced without context and so another significant principle is that discourse can only be conceived with reference to its historical context, contemporary and subsequent discourses (Fairclough and Wodak, 1997). Discourses are always connected intertextually to other discourses, produced in the past. Therefore, discourse was analysed in conjunction with previous knowledge of historical factors (Wodak, 2011) and how this affected the understandings and interpretations of mental ill health, reasonable adjustments and fitness requirements.

Principle 6 – Text and society are linked

This principle establishes a link between text and society, between micro and macro (Wodak, 1996). The actual, realised text and the wider social practices in which the text is submerged are mediated. This link is not direct, but manifested between socio-cultural processes and structures on the one hand, and properties of texts on the other (Fairclough and Wodak, 1997). In practice this means I have been looking at discourse from both the individual spoken texts and the wider social practices of the university and nursing and midwifery professions.

Principle 7 – Discourse analysis has both interpretative and explanatory intentions

These interpretations and explanations are authoritative and open to new contexts and information. Interpretation and understanding transpire through feelings, beliefs, values and knowledge (Wodak, 1996). This study was not only able to interpret discourse used by participants and within documents, but also provide some explanations about its impact on the student's ability to meet fitness to practice standard.

Principle 8 – Discourse is a form of social action

The aim of CDA is to expose opaqueness and power relationships, so to advance social change through the promotion of emancipatory knowledge. Unlike other discourse analysis, the interests of the critical discourse analyst, is made explicit (Fairclough and Wodak, 1997). Therefore the aim of this research was always to

illuminate current discourses and power relationships which had the potential to influence the achievement of student's with a mental health label and highlight ways which can improve their learning experiences and ability to succeed.

Table 1 – Principles of critical discourse analysis

4.6.5 Power

Critical discourse analysts are interested in how discourse manipulates power relations which are sustained or challenged through texts written and spoken (Wodak, 2001). There is a body of literature which features an abundance of concepts of power. It is acknowledged that no single definition of power has been accepted as the correct one (Haugaard and Clegg, 2009) or should be compressed into one definition (van Dijk, 2008), but how we think and talk about power has been separated into two broad and contrasting concepts; 'power over' and 'power to'.

'Power over' suggests a person or institution retains power and has the capacity to exercise it over others. There are well-known contributors to the discourse of 'power over' debate; the most prominent are Dahl (1961 cited in Lukes, 2005), Backrach and Baratz, (1970) and Lukes, (1974) who presented the three dimensions of power in the 1960's and 1970's. In his seminal work, Robert Dahl (1961 cited in Lukes, 2005) talked about power in behavioural terms of A having power over B to the extent that she/he can get B to do something that B would not otherwise do. For instance, there has been much criticism of psychiatry as the dominant group openly demonstrates power integrated in legislative discourse which permits the deprivation of liberty under the Mental Health Act (HMSO, 2007). This dimension of power focuses on the observed exercise of power made by the decision maker and assumes conflict (Lukes, 2005).

This simple notion of power was diversified by Bachrach and Baratz, (1970) who argued that Dahl's definition assumed non-participation was a result of

apathy. He suggested a second dimension of power, exercised by excluding people from the decision making process. As an example, the dominant discourse of medicalisation of disability from the medical profession was for a vast amount of time, considered as fact, which left other interpretations off the agenda until the infamous development of the social model of disability (Oliver, 1990). However, while this recognises both the decision maker and non-decision maker, it excludes the wider social context and how discourse influences the exercise of power and suppresses unrealised disagreements (Lukes, 2005).

Lukes (1974) contribution to this debate incorporated a third dimension which expands on the previous discourses of power. He suggests power not only can influence people to act in a certain way or determine their participation in decision making processes, but he adds power can also influence the way people can perceive their wants, desires and interests, which they are not aware of. Lukes (1974, p. 23) states '*A exercises power over B when A affects B in a manner contrary to B's interests'.* For instance, the NMC (2010b) suggests students must disclose their disability or health issue in order to receive reasonable adjustments. However as a result of disclosing, students may experience discriminatory attitudes from others.

These three dimensions of power are useful as they focus on concept of domination, but it is unclear who has 'power over' or enables 'power to'. Is it people including educators or the social structures within the university and clinical settings, and can they be reduced to one type of power? Furthermore, a large majority of disability research has focused on the social model of disability, resulting in the exclusion of the individual, as its focus is on how society and institutions have the power to discriminate. Watson (2012) suggests disability research has omitted how power influences the ability of the student with a mental health label to challenge such barriers and therefore contributes to discourses around disabled people as victims of society. 'Power over' in this sense does not necessarily

produce the effect intended (Sayer, 2000) as demonstrated in the literature whereby disclosures do not always trigger reasonable adjustments.

Power is a universal and constitutive feature of society (Wodak and Meyer, 2009), not only exercised by the dominant group; but negotiated by language used within nursing and midwifery education (Fairclough, 1993) and by students and educators who may determine aspects of language (Woofitt, 2005). Power can be examined not only in the sense of behaviour of certain people that enable others to act independently, but to explore how discourses of laws, NMC regulations, norms, social identities or university structures that restrict and enable all people (Hayward, 1998). In line with Hayward's (1998) suggestion power does not always have to have a face, and can be exercised through the cultural and social practices of nursing and midwifery education which may not be observable (Lukes, 1974), but allows discourse at the textual level to be analysed, as both can affect and be an agent of power (Foucault, 1989).

4.6.6 Ideology

Other than power, CDA focuses on the theoretical concept of ideology, associated with critical theory. Ideology is described as social theory which develops beliefs and ideas about the way things are in society usually in association with power and dominance (van Dijk, 1998). Its power and ability to withstand removal is determined by its popularity and endorsement by others (Locke, 2004).

Critical discourse analysts are interested in how ideology creates and reproduces unequal power relations mediated by discourse within particular social structures (Weiss and Wodak, 2003; Reisigl and Wodak, 2009). Whether something is considered true or false, ideologies form the basis of argumentation (van Dijk, 1998) and is shared by members of a particular social group like nursing and midwifery educators or students (Reisigl and

Wodak, 2009). An ideology may not be identically shared by all members of that group, or applied in the same way (van Dijk, 2011).

An ideology uncontested and consensus secured which allows certain groups to assume and sustain a position of power (Fairclough, 1995) without force are regarded as hegemonic. This largely prohibits people to acknowledge alternative positions. For example, the stereotypical and prejudicial ideology found in the media and illustrated in the studies around students and mental health could be present within nursing and midwifery education.

Therefore the intention of critical discourse analysts is to discover the hegemony of such discourses, how they are maintained or resisted and their causal effects (Joseph and Roberts, 2004) in order to enable students to reach their full potential and create a diverse NHS workforce that represents the community it serves.

4.6.7 Discourse-historical approach

The approach adopted within this study is predominately associated with Ruth Wodak (1996; 2001; 2011) and Reisigl and Wodak (2001). Studies conducted using this framework include discourses of sexism (Wodak, 1997), racism and anti-Semitism (van Leeuwen and Wodak, 1999; Reisigl and Wodak, 2001), national identity (Wodak et al., 2009) politics (Wodak, 2011) and disability (Grue, 2009; 2013; 2015). What makes it mildly different from the previous approaches mentioned is its analysis on the historical contexts and the use of discursive strategies.

Critical Discourse Analysis's central theme is its critical attitude to analysing discourse. As a critical theoretical approach, mental health, reasonable adjustments, and fitness requirements are not solely described (Baker et al., 2008), but attempts are made to explain their origins. The intention is to

unmask the circumstances for their emergence, preservation and resistance of discrimination by text (Reisigl and Wodak, 2009). Text in this context refers to *'the written or spoken language produced in a discursive event'* (Fairclough, 1993, p. 138).

Discourse-historical approach adopts a socio-philosophical orientation of critical theory and therefore takes into account three dimensions of critique in order to gain distance from the data. The first dimension; discourse immanent critique enabled me to examine and identify discourse inconsistencies, contradictions and dilemmas (Wodak, 2001) as they appear and reveal how they are sanctioned and transformed through discursive strategies. The critique also enabled me to explore suppression, in that what is not included in the text will be revealed (Billig, 1991).

The second dimension; socio-diagnostic critique is concerned with illuminating persuasive and manipulative elements of discursive practices transparent. It is concerned with identifying social and political goals and functions of discursive strategies, exposing the responsibilities and speakers contradictory, opposing, ambivalent claims and interests from either discourse, contextual, social, historical and political knowledge (Reisigl and Wodak, 2001). The dimension allows for my own background and knowledge to come through which allows a normative framework to identify fallacious and sound argumentations (Reisigl, 2014).

Finally the third dimension; prospective critique aims to make the discourses transparent and contribute to the improvement of communication with the intention of avoiding disablist language in the future (Wodak, 2001). This will be achieved illustrating the status quo and its influence on students which will then enable the development of a revised picture which works towards the emancipation of disabled students.

4.6.7.1 Discursive strategies

Fundamental to discourse-historical approach is the attention towards the use of discursive strategies. Reisigl and Wodak (2001) define strategy as a specific and more or less deliberate plan of practices in order to achieve social, political, psychological or linguistic aims. A discursive strategy is a systematic approach of language use (Reisigl and Wodak, 2001). The analytic approach aims to analyse the justifications for discursive strategies and their persuasive nature, stemming from implicit social opinions conceivably taken for granted, potentially unchallenged (van Dijk, 2005) and legitimised (van Leeuwen and Wodak, 1999). The discursive strategies investigated are drawn from Reisigl and Wodak's (2001) research on racism.

The first strategies to be investigated are referential strategies, also known as nomination strategies. These are ways in which the texts construct and represent students with a mental health label. Texts can demonstrate a referential strategy which reference in-groups and out-groups by membership categorisation devices like medical, depersonalising metaphors, metonymies (figure of speech whereby something is not called by their own name), synecdoches (simultaneous understandings (also a figure of speech whereby for example a person is referred to in the form of a part to represent a whole). Referential strategies can identify people or groups by derogatory terms, insulting meanings with no justification in order to perform disablist utterances (Reisigl and Wodak, 2001).

The second, predicational strategies are demonstrated when a person or group is linguistically referred to through stereotypical and evaluative traits both implicit and explicit. The strategies intentions are to label a person or group either positively or negatively. They are employed to attribute particular discursive characteristics of participants, phenomena, events and actions. They allow the construction of 'them' and 'us', enabling the speaker or writer to make negative or positive judgements about people or groups (Reisigl and Wodak, 2001).

Third, are argumentation strategies, which are ways in which people or groups attempt to justify, legitimise or refute the exclusion, discrimination, prejudice, suppression and exploitation of others, with the aim of establishing agreement (van Eemeren et al., 2010). The study of argumentation is to illustrate how conclusions are reached and how the premises of such conclusions can be explicitly implied or communicated implicitly without declaring them, making them more persuasive and less likely to be challenged (Reisigl and Wodak, 2001). These are achieved through topoi; parts of an argument which belongs to the proposition. They are the conclusion rules which link the argument to the conclusion (Reisigl and Wodak, 2001). For instance, the topos of danger justifies the conclusion that students with a mental health label considered dangerous should be prevented from entering the nursing and midwifery profession.

Perspectivisation strategies focus on positioning participants or writer's point of view. This can be demonstrated by strategies of involvement by placing self within the discourse. This can be established by references including 'we' or 'I'. As well as involvement, people may also refer to others in order to distance self from the discourse, or make reference to how they position themselves in relation to others. An additional distancing strategy may include speakers who make reference to derogatory assertions but illustrated through direct quotes as representatives of other peoples' views (Reisigl and Wodak, 2001).

The final discursive strategy is through intensification or mitigation. Intensification is how people make utterances overtly which sharpen their point or claim. Mitigation is how the claim is made less serious or by the use of individual words, for example, 'perhaps' or 'likely'. Throughout all of these discursive strategies, the speaker or writer may demonstrate positive self-presentation and negative other-presentation (Reisigl and Wodak, 2001).

4.7 Conclusion

The chapter has explored my ontological and epistemological positions which prior to the start of this project, was assumed to adopt social constructionism. Through my exploration around philosophical dimensions of mental ill health, I came to identify with critical realism. It is my belief that mental ill health has realist ontology but the language we apply to mental ill health has a social constructionist epistemology.

In response to the gaps identified in the literature review, I refined my research questions and chose to critically analyse discourse and its influence on nursing and midwifery educators and students' understanding of mental ill health, reasonable adjustments and fitness standards. This chapter has shown how I selected discourse-historical approach from the array of discourse analysis methodologies appropriate for an emancipatory research paradigm. A detailed account of the principles of CDA and their interaction with critique, power and ideology has been presented. As part of the discourse-historical approach, a detailed explanation of discursive strategies including argumentation has been explored. The following chapter will present a detailed discussion on how the research was designed and the data collection methods to address the research questions.

Chapter 5: Method and design

5. 1 Introduction

The previous chapter explored various philosophical and methodological frameworks resulting in the adoption of critical discourse analysis, namely discourse-historical approach, from a critical realist position. Critical discourse analysis is not viewed as a method (Threadgold, 2003; Baker et al., 2008) and does not require an approved research design (Meyer, 2001) but has to be congruent ontologically and epistemologically (Sayer, 1992). Nonetheless, critical discourse analysis is predominately associated with qualitative methods, which is conducive to the preferred approach taken in disability research (Alvesson and Sköldberg, 2009). Therefore the aim of this chapter is to illustrate the research design and methods utilised. Explanations for why the approach has been adopted, and how it enables to fill a gap within the current literature, will be provided. Included will be a description of the research setting, sample, recruitment procedures, data collection methods (both used and discarded) and data analysis. Also an account of how this research can justify its claim to be both ethical and trustworthy will be presented.

5.2 Research design

Critical realist and discourse-historical approaches endorse the use of more than one method. The intention is to ascertain a breadth and depth of understanding (Jonson et al., 2007) in a meaningful way (Creswell and Plano Clark, 2007). Historically, findings from mental health specific and disability research projects were frequently quantitative, resulting in the cause of mental ill health and other disabilities being understood as individual medical conditions (Smith, 2009; Pilgrim, 2015), based on diagnostic and statistical data. An alternative position considers mental ill health and other disabilities as socially, politically (Oliver, 1990) and economically organised (Davies, 2014; Pilgrim, 2015), therefore needing to

be researched qualitatively. This allows disability research to adopt an interpretive position, seeing knowledge as transitive rather than intransitive (Bhaskar, 2008), described in Chapter four (see 4.3.1).

Accordingly, qualitative research stresses the importance of understanding the social world and can demonstrate a social phenomenon via competent descriptions which can challenge accepted assumptions about the way things are. This can provoke the 'why' questions of explanatory research, but as discourse within this context has been under-explored, the 'what' questions needed to be asked. This has been achieved by exploring policy and guidance documents and participants' use of discursive strategies and argumentations (Reisigl and Wodak, 2001) of mental ill health, reasonable adjustments and fitness to practice standards within an educational setting.

Qualitative research can make use of a variety of methods, but documentary analysis and semi-structured interviews are considered appropriate in critical discourse analysis research and in this context. The use of both methods has enabled the exploration of similarities and differences between talk and text, thus providing a fuller picture of the phenomenon under investigation (Lincoln and Guba, 1985). For this to be a successful research project, which aims to move closer to the emancipation of disabled students, I felt it necessary to involve disabled people in the research design.

5.3 Experts by experience

Both the disability emancipatory research paradigm and INVOLVE (Hanley et al., 2004), part of the National Institute for Health Research, influenced my decision to include people, who have first-hand experience and knowledge of mental ill health and pre-registration higher education in the research design. Amongst emancipatory research literature it assumes disabled people are the objects of disability research, rather than the researcher (Danieli and Woodhams, 2005). Oliver (1992) suggests the

balance between the researcher and researched is to be ameliorated and control of the research process requires to reside with people with disabilities. This proposes disability research is to be consummated by disabled people or at least be involved in the design.

Therefore, if the goal of this approach is to ensure disabled people have full control of the research process (Oliver, 1993) it could be argued that as a disabled person who uses a university's disability service, personal knowledge and experience was all that was required to ensure the planning, design, data generation, analysis and report writing was in the control of a disabled researcher. On a *prima facie,* this is a valid argument. However, despite my personal experience of being categorised as a disabled student, warranted by a diagnosis of dyslexia, I felt it unjustifiable to insinuate I have direct knowledge of mental health and therefore I cannot be considered an expert (Stone and Priestley, 1996). Furthermore, as disabled people are a heterogeneous group who possess differing idiosyncrasies, experiences and voices, the emancipatory paradigm which makes limited citation to mental ill health, needs to be inclusive of all impairments.

Similar to the Care Quality Commission (CQC) (2015), I use the term 'experts by experience' when referring to the two ex-students who were consulted throughout the study. One expert recently registered with a regulatory body and received support from a Disability Support Allowance (DSA) (Education (Student Support) Regulations, 2011) during his/her pre-registration programme. The second expert had previously been asked to leave a pre-registration course due to mental health issues, and was not aware of reasonable adjustments. Both were well at the time of their involvement and had been managing their mental health for some years. One other expert was identified, but did not want to participate.

There was recognition that as researcher, a position of power and perceived notion of 'expert' (Danieli and Woodham, 2005) would have

influenced the relationship. To ensure an ethical and emancipatory study, experts were encouraged to take as much control over the consultation as was achievable, including meeting arrangements, sharing ideas and ability the to provide critique in a safe and welcomed manner.

The emancipatory research approach corresponds to the INVOLVE (Hanley et al., 2004) principles which promote the involvement of people, starting with identifying topics for dissemination and evaluation, achieved through consultation, collaboration and/or user control. Oliver (1992) argues that empowerment of disabled people is successful if full control of research production is placed with disabled people and anything less is incongruous to emancipatory research. Due to the nature of a PhD study, the experts' perspectives around the research topic, design, practicalities and appropriateness of data collection, and my interpretation of findings, were welcomed. Experts were excluded from conducting data analysis, writing up and dissemination of findings. However, consulting experts during the various stages of the study, not only enhanced the research design with their reflections, ideas and criticisms, but aided a reduction in my own bias. Their contribution to the research and my own reflexivity was invaluable and will be discussed throughout when input was received.

5.4 Reflexivity

As a critical discourse analyst, it was important to recognise that the interpretations and critique presented was not situated outside of discourse (Jäger and Maier, 2009), but influenced by social including the discourses of critical discourse analysis (Chouliaraki and Fairclough, 1999). This supports the view that research is mediated both consciously and unconsciously by epistemic blinkers (Kanth, 2004) in that discourses, knowledge and assumptions of existing culture and social norms are not privileged access to reality, only perceptions. It can also be argued that the methodological approach is "*a production of conviction*..." (Verschueren, 2001, p. 65), due to the concentration on how dominant groups are

constructed and maintained within discourse. Furthermore, certain interpretations will seem more significant than others (Wodak, 2001) and may be seen as having a better understanding and attitude than others (Reisigl and Wodak, 2001).

This has been reduced by observing caution and by presenting the analysis transparently for the reader, but also by advocating self-reflection at multiple stages of the analysis (Breeze, 2011). To aid this, the experts by experience contributed to the fundamental characteristic of critical discourse analysis (Reisigl and Wodak, 2001) and overall trustworthiness by helping me ensure the research construction was reflexive.

Reflexivity means the investigation incorporated an ongoing evaluation of my role as researcher and the activities conducted within it (Fairclough, 1995; Yardley, 1997a). Shakespeare (1996) suggests that researchers can be independent but does not necessarily result in objectivity and neutrality, while Widdowson (2005) argues a lack of impartiality due to critical discourse analysis focus on ideological meaning, may ignore contradictory data.

Elaborating on this point, Green (2007a) argues that the researcher conducts their research through a diversification of theoretical commitments, experiences, beliefs and values, referred to as a mental model. Critical realism plays an important part in this as the philosophical perspective acknowledges the need for reflexivity. Archer (2000) considers reflexivity as a part of being human. In the context of this study, it allows for previous positions and discourses to be questioned and changed if required.

Personal reflexivity (Willig, 2008) is important as my biography and experience of being a disabled student needs to be acknowledged, as I am not without prejudice. However, just because I have knowledge of being a disabled student, doesn’t mean I am a member of the group of students

within this study. This is especially so as my experience is outside of nursing and midwifery education and practice. However, I am clear that my experiences and sociological understanding of self (Greene, 2014) does not render me free from bias, but a truly independent researcher may be deemed unobtainable (Shakespeare, 1996). I have limited personal and professional experience in mental health, which gives me some distance from the topic. However it is pertinent for the reader to understand that this project is designed and analysed through the research lens of a disabled person whose previous professional role was to challenge inequality.

Initially, the study was going to explore the experiences of students with a mental health diagnosis during their pre-registration programme. However, at the embryonic stages of the PhD two significant events took place, triggering a further exploration of the role of discourse in nursing and midwifery education for students experiencing mental ill health. The first was a reflection on my experience of a dyslexia assessment I undertook, which resulted in a number of reasonable adjustments. The second was a consultation meeting with experts by experience (see 5.3 for further discussion). Both illustrated the negative lexical choices used by both disabled and non-disabled people, which became of interest. A further review of the literature illustrated the absence of discourse research on student mental health and reasonable adjustments within nursing and midwifery education.

It is through my experience that I am able to utilise an intimate and studious knowledge on the topic, which may have contributed to illuminating covert meanings and connections within the data (Yardley, 1997b). Nonetheless, disclosing a transparent description of my mental model, including my motives, how it was incorporated into the research process (Nightingale and Cromby, 1999; Corbin and Strauss, 2008) and influenced the conclusions, will enable the reader to locate me in the data (Mason, 2002), identify my potential for bias and make their own judgements (Yardley, 1997a).

A reflexive journal, used throughout, enabled me to develop my reflexive skills. The journal helped to identify my own understanding of self (Greene, 2014) including how personal experiences, feelings and uncertainties (Carlson, 2010) may have contributed to the design and data analysis. For instance, as a guest lecturer and practice mentor for a social work programme prior to this project, and as a disabled student, I was conscious of how people involved in student placements would talk about disability. I observed that language underpinned by the deficit model of disability (Dyson, 1990), whereby the focus would be on what the student couldn't do, took precedence over external factors and the student's ability. What especially stood out was the powerful impact of positioning self as a student informed me of a hidden disability, prior to telling me his/her name. I was intrigued by the negative lexical choices used to describe his/her disability and why the student placed his/her disability at the forefront of his/her identity. In response to my own disclosure of dyslexia, peers and university staff have interpreted my disability as a lack of confidence, or have attributed some personal challenges as a common experience amongst PhD students as a whole. This experience not only enabled me to question the influence of discourse, but also comprehend the consequences of what is being said (Corbin and Strauss, 2008).

5.5 Data collection methods

Following an amalgamation of a discourse-historical approach (Wodak, 1996; Reisigl and Wodak, 2001) and principles of an emancipatory research paradigm (Oliver, 1992), the aim of the research was to identify how nursing and midwifery education can deliver an inclusive educational environment in order for students experiencing mental ill health to reach their full potential. The research was conducted in a UK university that provides various pre-registration programmes across a number of professional fields including social work, nursing and midwifery, physiotherapy, occupational therapy, radiotherapy and optometry. Originally all programmes were going to participate in this study, but there was a

concern that the research design would not protect anonymity of all participants due to the small sample available within come programmes. As nursing and midwifery was on of the largest programmes within the university, anonymity would be granted. During the research design stage, a number of data collection methods were considered including focus groups and participant observation, however both were later discarded.

Focus groups fit comfortability with emancipatory research as the approach enables individual voices to be heard and enhances collectivisation of views and experiences (Stone and Priestley, 1996) in a supportive environment. Critical discourse analysis within focus groups is effective at exposing power dynamics between participants and could have illuminated how dominance is sanctioned (van Dijk, 2008). However, following informal discussions with the university's disability office and the experts, it became apparent that students were reluctant to disclose their mental health diagnosis to their peers due to perceived stigma. Furthermore, focus groups participants generally don't know each other (Flores and Alonso, 1995), but considering the small size of the sample population, anonymity of participants could not be guaranteed (Robson, 2011), so openness and comfortableness may be constrained, especially if discriminatory discourses are expressed.

Participant observation, a method which has its origins in anthropology, was briefly considered as language and the ways in which particular social practices are utilised are central (Gray, 2009). Potentially, the extensive contact within the university and practice placements would have allowed the research to explore people in various natural settings and make links between talk and context (Bryman, 2012). Although there are some benefits to this method, potential risks and ethical issues reviewed made it an impractical option. Firstly the overt presence of an observer would have affected how people may behave, especially in situations which only included the student and an educator. Secondly, if observation was to include mentors and students in clinical environments, informed consent

would have been difficult to obtain due to the amount of patients they could have come in contact with. Both these points would have made the method an intrusive one for all participants and patients.

To discover how text and talk constructed student mental ill health, reasonable adjustments, and fitness requirements, the research was organised into two stages. Firstly, documentary analysis of relevant NMC guidance and university policies followed by, semi-structured interviews of students, lecturers and clinical mentors. The two data collection methods were utilised in order to not only take into account the discourses used by participants, but also critically analyse them in relation to documents (Smith and Elger, 2012) which they are expected to follow.

5.5.1 Stage 1: Documentary Analysis

Documentary analysis is under represented within social sciences, but as socially situated products (Scott, 1990) the method can be advantageous in analysing documents which comprise of information about or relevant to the phenomenon under investigation (Bailey, 1994). Documents refer to physical sources, predominately written and in both the public and private domains (Payne and Payne, 2004), produced by individuals and groups with a particular function (Scott, 1990). Within this research, all documents have a particular function within nursing and midwifery pre-registration education and therefore it is probable they will influence the discourses of students and educators. This makes them secondary data sources as they have not been produced specifically for this research (Bailey, 1994). If participants have read them, as is expected, the documents may influence instances of the discourses used by participants.

5.5.1.1 Inclusion criteria

The main criteria used to determine the eligibility of documentation was based on their role within the nursing and midwifery programmes within the

university under investigation. The types of documents included had to be relevant to student assessment on placement and/or included procedures and practices specifically for students with disabilities. Documents included also met Scott's (1990) criteria, presented below. The criteria includes:-

- Authenticity (are they genuine?)
- Credibility (free from error and distortion)
- Representativeness (typical of its kind) and
- Meaning (are they clear and comprehensible?).

5.5.1.2 Authenticity

Authenticity makes reference to the genuineness, reliability and unquestionable origin of the documents. To ensure this fundamental criterion was adhered to, all documents were accessed from official online sources. Platt (1981) makes reference to different versions of the same document, and as policies and procedures have a tendency to be regularly reviewed and updated, it was necessary to ensure the latest version was accessed. Scott (1990) also refers to authenticating the authorship by ensuring the name on the document is genuine. However this can be problematic as policy and procedural documentation are usually written by numerous people. With regards to the Nursing and Midwifery Council, documents are generally authored by the current Chief Executive and Registrar. University policies within the research were somewhat dissimilar and inconsistent. For example, the University's Student Fitness to Practice (SFtP) procedures although accessed via their website, could have been produced by a non-university member of staff as no authorship or logo was present. In spite of this, there was no guarantee this particular version was the current policy as no version number or date was obtainable. Authenticity was not taken for granted in this instance but there is an element of trust. The genuineness of this document was confirmed by the university's disability office.

5.5.1.3 Credibility

Credibility refers to ensuring documentary sources are free from error and distortion (Scott, 1990). All documents were prepared externally to the research and by other people or groups, none of whom I have any influence over. Scott (1990) characterises this as ‘mediate access’, suggesting they have been produced in the past, rather than ‘proximate access’, which refers to sources created in the presence of the researcher. As all documents are in the public domain and authors were unaware at the time of access that these documents would form part of the data, I am confident that all documents are accurate and have not been altered to deceive the researcher.

5.5.1.4 Representativeness

Representativeness refers to documents which are typical of their kind and is a term that can be applied to some documents more than others. For example, NMC policies are written in a consistent vernacular and have similar content (Platt, 1981) throughout which demonstrates its representativeness. This is slightly more difficult to ascertain when such documents are in their infancy and only the first version exists, which is the case with the Student Fitness to Practice (SFtP) procedure. Even though it didn’t fit neatly within this criterion, it’s relevancy to the phenomenon under investigation meant it required further scrutiny and therefore was included.

5.5.1.5 Meaning

Meaning applies to whether the evidence is clear and comprehensible. The main purpose of analysing documents is to gain some understanding of both literal and interpretative meaning and implications to the phenomenon under investigation. Scott (1990) posits a document’s literal meaning only

presents its face value meaning. Interpretative meaning relates situationally as the context is determined by social and cultural factors and therefore cannot be analysed outside the context of nursing and midwifery education (Danermark, 2001). Platt (1981) adds the importance of deciding what interpretations to make from a document other than information which is regarded as factual. Considering this study adopts a critical discourse analysis methodology, all documents have been read with the intention of identifying how ideology and power is illustrated by language use (Wodak and Meyer, 2009).

It can be argued that having a greater understanding of the policies and procedures pertinent to nursing and midwifery pre-registration education would be beneficial to the interview process. The intimate understanding and knowledge gained from the documents will be useful in explicating language used by participants which may enhance my repertoire of potential probing questions. I was confident that documentary analysis was congruous to this area of study, as there are examples of previous studies in this area (Sin and Fong, 2008; 2009).

5.5.1.6 Exclusion criteria

Policy documentation which has been updated subsequent to the interviews was excluded. Analysing new versions of policies and procedures would not have demonstrated a temporal representation and therefore would have made triangulation with participants' language use inaccurate (see 5.5.2.7 for a discussion on triangulation). Probing interview questions regarding policy and procedures were informed by the versions which were in place at that time.

Documents not directly related to nursing and midwifery students were excluded as they probably did not influence the students experience specifically within this programme. Documents which were difficult to get

hold of, or inaccessible to participants, were also excluded. The justification was due to their incompatibility with triangulating discourses employed by participants on specific areas with the discourses utilised in documentation they are expected to read.

5.5.1.7 Sampling

Identifying an adequate representation of a particular population is not congruous with a qualitative design as the intention is not to gain limited data from a large sample (Yardley, 1997b). However, as language is a means to gain and maintain power by the use 'powerful' people make of it' (Reisigl and Wodak, 2009, p. 88), it was important to gain an insight into discourses employed in key texts utilised by students and educators of nursing and midwifery education at a particular UK university. The most appropriate strategy was purposive sampling (Lincoln and Guba, 1985) as the research required rich data central to the research questions.

Certain documents were targeted (see Appendix 11 for the full list of documents), allowing the focus on gaining access to discourses on salient topics which influence students and their nursing and midwifery education programme. Even though I had an understanding of these topics; mental health; reasonable adjustments and fitness requirements, I was inquisitive about how they were understood and which discourses influenced educational practices.

5.5.1.8 Data analysis of documentation

Critical discourse analysis does not assert a particular analysis method, but this study was done in stages. The stages were dependent on the time of access to the data; therefore as the documents were already in written format and available prior to interviews, analysis was able to begin immediately. Analysing these documents first also aided probing questions when such documents were referred to in the interviews.

Firstly, all of the documents were read through in order to reflect (Clarke, 2005), become familiar with their content (Gill, 1996) and capture the essential nature of what was being read, without any note taking or coding. The second stage was to re-read each document, and take notes, while paying attention to the key areas in relation to the research questions and methodological approach. This included isolating specific references to mental health, students, reasonable adjustments, and fitness requirements, both directly and indirectly related to the research questions. In keeping with the principles of critical discourse analysis and the discourse-historical approach, the three dimensions of critique; discourse immanent critique, socio-diagnostic critique and prospective critique (see 4.6.7 for further discussion). The third stage was focused on the discursive strategies including argumentation strategies, (see 4.6.7.1 for a detailed discussion).

Throughout the analysis, quotes were transferred on to a matrix-style spreadsheet alongside analytic notes in order to create a visualisation of the dominant discourses and how they connect to the research questions. This also allowed a reduced but relevant amount of data to be analysed again, enabling additional comprehension (Potter and Wetherall, 1987).

5.5.2 Stage 2: Interviews

Conducive to a critical realist research and discourse-historical approach, it was important to conduct interviews as part of the wider research design, in order to gain access to a breadth and depth of understanding. Therefore the second stage in data collection was conducting in-depth interviews. There is a plethora of interpretations of what an interview comprises of. Robson (2011) makes the division between three approaches; structured, unstructured and semi-structured interviews. These can all be achieved face-to-face or via the telephone.

Interview approaches were discussed with the ex-student expert. Other forms of interviews were deemed inconsistent with an emancipatory and critical research design (Barnes and Mercer, 1997; Oliver, 1992). For instance it was suggested that the structured interview disconnects with a critical discourse analysis and emancipatory research. This approach permits the researcher to take full control of the interview experience and prohibits interviewees to freely explore their own understanding and opinions. Furthermore, structured interviews precision of question delivery does not allow the interviewer to ask theory driven questions, resulting in data only related to a coding scheme established prior to the interview would be acknowledged (Fontana and Frey, 2005).

At the other end of the spectrum, unstructured interviews with possibly one initial question would permit an unrestricted area of interest. This would allow the interview to seem less obtrusive and enable the interviewee control over the topic and interview, a design conducive to Oliver's (1992) emancipation research paradigm. However, the openness doesn't give assurance to apposite data in order to answer the research questions and be context-dependent; a requirement of critical realist (Sayer, 2000) and critical discourse analysis research (Fairclough and Wodak, 1997). The approach does not guarantee the contribution to the body of knowledge required for a PhD study (Phillips and Pugh, 2010), as interviewees may talk about issues that have already been identified within the literature.

Reasons why face-to-face semi-structured interviews were chosen as the most appropriate method includes, ensuring the research questions were answered. It can be argued that a pre-designed interview schedule allowed the research to focus on the topics of mental ill health, reasonable adjustments and fitness requirements. This allows for the prevention of a distorted and peripheral illustration of the phenomenon under investigation, but at the same time allows interviewees to know what they are consenting to.

Furthermore, due to its pliable nature, the guided interview via open-ended questions and prompts were able to explore concepts and discourses further and modify any questions as a reaction to subjective (Peräkylä and Ruusuvuori, 2011) and unexpected responses and ensure interview flow (Fontana and Frey, 2005). The approach legitimises probing questions to seek out the intricacies of interviewees' justifications and argumentations behind the discourses expressed, in line with a discourse-historical approach to critical discourse analysis. As previously mentioned, discourse is under explored within disability studies (Grue, 2013), but various studies with a focus on students with disabilities (Holloway, 2001; Morris and Turnbull, 2006; White, 2007; Vickerman and Blundell, 2010; Murphy, 2011; Mortimore, 2013), student mental health (Olney and Brockelman, 2003; Mullins and Preyde, 2013), reasonable adjustments (Holloway, 2001) and fitness to practice standards (Stanley et al., 2007a; Sin and Fong, 2009), have successfully utilised face-to-face semi-structured interviews.

Telephone interviews were considered but dismissed as they would not afford the interviewer the visual cues from the participant that often lead to probing questions and contextual data. The absence of these may have been detrimental if conducted over the telephone (Garbett and McCormack, 2001). Despite comparative literature available on face-to-face verses telephone interviews (Sturges and Hanrahan, 2004), it was felt face to face would ensure rapport, something essential to qualitative interviews (Fontana and Frey, 2005). The benefits of telephone interviews, including the location of the participant (Sturges and Hanrahan, 2004) and reducing cost, were both considered not to be an issue with this study.

The use of semi-structured interviews enabled some control to reside with interviewees. For instance interviewees were informed at the start that speaking up about not answering unwanted questions was welcomed. On one occasion, an interviewee was asked if the interview needed to be discontinued due to emotional distress. After a short pause they decided they did want to continue.

What is important to this type of study is the balance of power between the researched and researcher (Oliver, 1992); a position aspired towards, but not completely met. A great deal of reflexivity concentrated on identifying and reducing power relations during the interview. One such course of action was to acknowledge my lack of professional experience in nursing and midwifery, which intended to reduce the assumed role of expert, a process promoted within feminist research (see Oakley, 1981) and disability research approaches (see Oliver, 1992).

To establish a reciprocal relationship, I considered sharing my own experiences of being a disabled student. Despite its potential to procure better responses (Douglas, 1985 cited in Holstein and Gubrium, 1995), my decision to not disclose my disability was concerned with influencing responses to questions (Koro-Ljungberg, 2008). I was mindful that people may not have been so open if they thought I would have been personally affected by some discourses interpreted as discriminatory. Other researchers have chosen to disclose their disability. For instance Olney and Brockelman (2003), who consider themselves to have hidden disabilities, informed interviewees at the start of their interviews. It is difficult to ascertain whether this is common amongst researchers as many studies do not present this information.

5.5.2.1 Interview Inclusion and Exclusion criteria

To ensure the research questions were able to be answered, the interview inclusion and exclusion criteria was a vital component of the study and were as follows:

<u>Students</u>

- Students enrolled on a pre-registration nursing or midwifery programmes at a specific university in the north of England;
- Who have completed at least one placement

A number of suggestions were made in order to gain access to an adequate sample size which encompassed a variation of participants. For instance, senior educators suggested the focus on students with a mental health label was not going to lead to an appropriate sample size as it was perceived that student mental ill health was low within the faculty. This supported the view of one expert by experience who said she was the only person she knew with a mental health label during the years attending the university. It was envisaged that non-disclosure was highly probable due to a plethora of similar findings illustrated in the literature review. Therefore the inclusion criteria of students were not specific in terms of disability or an absence of disability.

Lecturers

- Nursing and midwifery lecturers employed by the university under investigation;
- who teach on the pre-registration programmes and
- who have some involvement in recent student placements.

Clinical Mentors

- Nursing and midwifery clinical mentors with experience of mentoring at least two students, or
- who had some involvement in the assessment process in clinical settings which provide placements for the nursing and midwifery faculty at the university under investigation.

With both the lecturers and clinical mentors it was not essential to have experience of teaching students who were known to have a mental health label or other disability, but was deemed an asset to the research.

5.5.2.2 Interview Sampling

As generalisation was not the aim of the study, purpose sampling was used. The rationale was to gain access to participants who had direct involvement in nursing and midwifery education but who had differing roles within this setting. The strategy was also chosen to utilise an achievable sample with the available resources, practicalities, and within a certain timeframe (O'Leary, 2014). Furthermore, a purposive sampling strategy was deemed appropriate as the philosophical and methodological approaches required information rich data central to the research questions (Denzin and Lincoln, 2011).

Once the inclusion criteria were drawn up, measures were put in place to ensure participants across both nursing and midwifery were sought. During the recruitment process, it became apparent that few participants from midwifery and mentors across both professions came forward. With regards to students and lecturers, this was likely due to the midwifery programme being much smaller than the nursing programme. Towards the second half of data collection, no mentors had volunteered to participate. To ensure a diverse and representative sample, additional recruitment activity occurred, in order to fill these gaps.

Halfway through the interviews, snowball sampling was initiated by few participants who had completed their interviews. These participants acknowledged peers who may wish to participate in the study. As participants were not asked how they became to be involved, it is unknown how many volunteered to participate as a response to snowball sampling, but one interviewee did acknowledge being informed by a previous participant. It is acknowledged that this method of sampling brings an element of bias into the sample as participants may invite certain people who share certain beliefs about the areas of investigation (King and Horrocks, 2010), however, similar constructions and ideological positions were demonstrated by all participants.

5.5.2.3 Interview recruitment

Designing the recruitment strategy was a lengthy undertaking. Following informal discussions with senior academic and clinical staff, various tailored recruitment strategies were drawn up to enable access to different clinical locations and various academic timetables.

A two-pronged approach was taken to ensure a diverse range of people had access to information about the study. Paper and electronic based methods as well as face to face presentations were utilised simultaneously. Once key people who were able to give access permission within both academic and NHS settings were identified, information sheets were electronically distributed to all potential participants via academic and clinical managers. Also in one hospital, as requested by a senior manager, a poster specifically for midwife mentors was displayed across relevant notice boards.

As mental health stigma impacts upon research participation, resulting in fewer research volunteers who may identify with a mental health label (MRC, 2010), face-to-face group presentations to inform potential participants were undertaken to enable more inclusivity and accessibility (see appendix 6). It was important to express a commitment to confidentiality, anonymity and respect to potential participants. The main suggestions from both academic and clinical leads were to present in student lectures and staff meetings. As students across both programmes were in university at different times during the academic year due to placement commitments, presentations were held over a six month period. For anonymity and practical purposes due to lecture sizes, no information sheets were given to students at this time. Instead, students were informed about where the information sheet was displayed. The main location was on Blackboard, an online tool which allows faculties to add resources for students to access. Senior mentor staff recommended conducting the invitation to participant presentation during staff meetings and mentor

update meetings. As these were all much smaller than the student lectures, I was able to give an information sheet to all mentors within each presentation session.

Towards the end of the initial data collection, no mentors had volunteered to participate. It is believed that work commitments influenced their decision. It was felt important to ensure their inclusion considering their involvement in students' placements, and therefore the recruitment timeframe was extended. Several additional presentations were delivered. In total, five mentors showed an interest in participating. However, two of the five were difficult to set a date for interview, and after a couple of attempts, it was assumed that their decision to participate had changed so no further attempts at interview dates were pursued.

It is estimated that I delivered my research invitation presentation to 300 potential participants. This was during three student lecturers, two academic staff meetings, two clinical staff meetings and six mentor update training sessions over the six month period.

5.5.2.4 Details of the final sample

Despite the intention of recruiting an equal number of students, lecturers and clinical mentors, recruiting 23 participants was deemed a success, as my aim was 24. As the midwifery programme was significantly smaller in size than nursing, it was envisaged that two-thirds of the participants would be nursing, which was also achieved. Due to the substantial difference in samples and the small sample as a whole, it is considered inappropriate to draw on comparisons between the two professions.

Finally, as nursing and midwifery is still a female dominated profession and that some male participants took part, it was felt that writing up the gender differences of the sample would not ensure anonymity of male participants.

Also due to the small sample, it was felt that other demographics would not contribute to the research findings, so this information will not be included. Table 2 below illustrates a breakdown of the 23 semi-structured interviewees.

	Nursing	Midwifery
Students	8	1
Lecturers	7	4
Clinical Mentors	2	1
TOTAL SAMPLE	**17**	**6**

Table 2 - Details of the final interview sample

5.5.2.5 Development of interview guide

During the development of interview questions, the words used to construct each question were reflected on as they played a crucial part in how others would interpret their meaning and therefore the findings (Willig, 2008). This was a challenge when deciding on the lexical choice to denote mental ill health. The literature review highlighted the various terms used, all of which construct different versions of reality, invoking different meanings. However, after consultation with experts by experience, the preferred term was mental ill health. Other questions were reviewed and minor modification was made in order to make the questions more transparent.

A pilot study was considered with the intention of testing how well the interview questions functioned (van Teijlingen and Hundley, 2001) in order to answer the research questions and assess data bias. Following various informal discussions with disability officers, academics and NHS professionals not participating in the study, it became apparent the potential difficulty in recruiting an appropriate number of lecturers and clinical mentors for the study due to time commitments. This was reiterated during discussions with the experts by experience as the schedules for pre-

registration student nurses and midwives were intense. The decision was also governed by the experts alongside a plethora of literature which confirmed a fear of disclosure was still prevalent within higher education. Therefore the risk of conducting pilot interviews within an already potential small group of people was too high. Retrospectively, this decision was considered correct as the sample of mentor participants in particular was slightly lower than intended.

Furthermore, a pilot study would not have been compatible with my ontological and epistemological position, as the study explores discourses utilised on a particular day, on a particular issue and so the method did not need testing for consistency. This is especially pertinent to probing questions which are dependent on the discourses used by a particular interviewee, so consistency is not always appropriate. However, the interview questions were presented to the experts by experience to ensure they were understandable and appropriate. The experts were able to identify any potential practical problems which may have arisen with regards to the whole research process.

5.5.2.6 Conducting interviews

Before the interview questions were asked, I wanted to make sure participants fully understood what they had previously consented to. For most, it was clear they had a good understanding of the research aims and content. However for a couple of participants, it was apparent that only a partial understanding of what the study entailed was established. Therefore I provided a recap on the area of study and an overview of what the questions would and would not entail in order to be reassured that consent was given. As a result, all participants continued with the interview.

The semi-structured interview schedule consisted of questions aimed at gaining an understanding of students, lecturers and mentors constructions around the main topics; mental ill health, reasonable adjustments and

fitness to practice standards. Whilst participants were asked similar questions, each were worded differently depending on their position within the nursing and midwifery programmes (see appendices 7-9 for the interview schedules). Before such questions were asked, each participant was asked what their role was or why they had decided to study nursing or midwifery. This was to enable participants to talk generally about themselves within the context of nursing and midwifery education. The intention was to lessen any feelings of it being like an exam or investigation.

The interview schedules were used as a guide and some wording of questions slightly changed to suit the participants' lexical choices during the interview. Probing questions were asked in order to allow participants to expand on their initial answer and gain more depth in their response (King and Horrocks, 2010). Even though peoples' experiences were not part of the study, some participants spoke of their understanding of mental ill health, adjustments and fitness standards in relation to their circumstances and experiences. As demonstrated in the findings, these anecdotes have formed part of the data as they reflect participants' constructions.

At the end of the interview, each participant was given a debriefing information sheet which provided additional information with regards to people they could talk to if they had any questions or concerns about the study. Furthermore each participant was informed that they had the right to withdrawn from the study up until the write up stage. No participant made contact regarding their withdrawal and so it was assumed that this indicated consent to use the interview data.

The spoken texts in their original form were audio recorded interviews which required transcription. As a dyslexic student, I had secured a Disability Student Allowance (DSA) which funded an independent transcriber. It became apparent from the initial transcripts that the transcriber lacked contextual knowledge (Cameron, 2002) as certain words and sentences were misheard or not understood and presented as asterisks. Therefore the first stage of interview data analysis began with

replaying the recording alongside the transcripts enabling the asterisk to be replaced with the spoken words. For the purpose of this research and methodological framework, silences and pauses were added. To ensure anonymity, all identifying words and sentences were replaced with other appropriate words.

5.5.2.7 Data analysis of Interviews

Fairclough (1995) asserts there is not a single way of doing discourse analysis, but it was important that the process of analysis was conducted appropriately and in a way which allowed me to manage a large amount of data. Initially I began using NVIVO, but it became obvious early on that this computer programme was not accessible to the way I process information. Therefore I put aside electronic tools available to me and began the process with pen and paper.

Immediately after each interview, field notes were written up and used to aid reflexivity. Similar to the document analysis procedure, the interviews, determined by the research questions, were read in three different stages which helped separate the text into attainable sections. This was very time consuming but helped me manage the amount of data I needed to process, something that would have been difficult if I had all three research questions simultaneously at once to explore.

Each transcript was printed out, allowing for initial analytical thoughts and areas of interest to be written in the margins. After completing each transcript, a reflective account was written in my research journal which allowed a summary of where I thought the data was going and why certain lexical choices and underpinning discourses were used. Once all transcripts were read through multiple times, I returned to the data and began the initial coding whereby I started locating and identifying different words, interpretations and patterns. Here the focus was on identifying the language used by participants when making reference to people, events, procedures and actions.

At this stage of the analysis, I wrote up my initial analysis and presented my findings at a nurse and midwifery education conference which resulted in a number of questions and valuable feedback. Next was the identification of how people, events, procedures and actions were characterised and evaluated. At this point, dominant discourses were beginning to appear which prompted me to re-read transcripts and seek further data and make connections which I may have missed during the initial stages. The following stage was focused on the participants' arguments around claims made, how they were legitimatised, from whose perspective were they verbalised and were they made overtly or mitigated.

To ensure the study did not become solely a project of identifying dominant discourses among a group of participants, the premise of triangulation was utilised. Triangulation is a research strategy that uses multiple methods (Streubert and Carpenter, 2011) and plays a significant role in the discourse-historical approach (Wodak, 2001). Both methodological and data triangulation methods were conducted. Methodological triangulation was accomplished through comparing data within documentary sources and interviews. Data triangulation was demonstrated by comparing students, lecturers and mentors responses within the intention of obtaining a variety of perspectives (Meyer, 2001).

To achieve triangulation, the relevant text was transferred to the matrix and examined again, allowing the study to reveal homogeneous, conflicting, contradictory and new discourses (Smith and Elger, 2012). In line with the discourse-historical approach, triangulation allowed the historical, political and social dimensions to be observed in relation to the specific discourses and discursive strategies by constantly switching between these domains (Meyer, 2001). Having knowledge of the historical background whereby the discourses are immersed and how these have changed over time is argued to enhance the analysis and reduces risk of bias (Wodak, 1996).

At the same time and throughout this process, I was regularly exploring how I interacted with the text by asking what I was reading and why I was reading it in the way I was (Potter and Wetherall, 1987). An awareness of

how my professional and personal biography and extant assumptions based on cultural norms influenced the interviewee responses were also taken into account and included in the matrix. Questions also arose about how independent my interpretation of the data could be and how bias could be reduced in order for the dominant discourses to surface (Reisigl and Wodak, 2009).

As a result, the initial interpretation of the findings was presented to the 'expert by experience', but at no time was access to the transcripts or recordings made available, so to ensure participant anonymity. The only aspect which was discordant was my interpretation of the illness model of mental health. On reflection this was not unexpected as a medical model of disability was the dominant perspective utilised by the expert in all of the consultation meetings.

5.6 Ethical considerations

Research ethics concerns the behaviour of the researcher in relation to people being researched and affected by it. Ethical decisions have been considered throughout from the design stage to dissemination. Ethical principles will be discussed within the context of this research in order to highlight ethical issues and how they were addressed.

Ethical approval was received from the university (21st March 2014, ref: E343) and NHS (11th February 2015, ref: 0645). The recruitment and use of experts by experience does not require ethical approval (Hanley, 2004; National Research Ethics Service (NRES) (2009). Even though their involvement has not formed part of the procedures to gain approval, ethical considerations are included in the discussion below.

Ethical considerations have been addressed and guided by Beauchamp and Childress (2009) who developed ethical commitments appropriate for research in health care and education. The approach utilises four ethical

commitments; autonomy, beneficence, non-maleficence and justice, each of which will be discussed below with regards to this study.

5.6.1 Autonomy

Autonomy is based on the principle of respect for participants by ensuring they have the ability to self-govern by understanding without any external forcing intervention (Beauchamp and Childress, 2009), therefore enabling people to make an informed decision about consenting to participate or not (Bulmer, 2001). Polit and Beck (2012, p. 157) break down informed consent into three parts; '*participants have adequate information about the research; comprehend that information; and have the ability to consent to or decline partication voluntarily'*.

Before participants were asked to sign a consent form (see appendix, 7) in order to formally document and confirm they had been informed about the research (Denscombe, 2010) and consented, all participants were given an information sheet (see appendices 2-4). The document included information regarding the research purpose, benefits and risks to taking part, expectations, the right to withdraw up until the write up stage without giving a reason, dissemination of findings, confidentiality and anonymity. Once they had received the information, they were given the opportunity to contact me with questions prior to consent. As the recruitment stage was undertaken over a number of months, potential participants were informed about when the interviews would end. This gave people an indication about how long they had to decide. However, each person was informed that they had a minimum of 24 hours to consent in order to ensure people had time to reflect on their decision. After which, people could contact me via email or telephone.

Initially students were going to receive information via the disability office as they would know of potential student participants. However, this suggests gatekeeping and potentially could result in conscious or unconscious over-protectiveness (Heath et al., 2004) on the part of the disability office. Alternatively students may have felt obliged or coerced into taking part (de

Vaus, 2001). For instance there was a concern that students would feel obliged to participate because they access reasonable adjustments or other support from the university. Despite no evidence or perception that students would be coerced into participation, I wanted to ensure all students understood that their education or disability specific support would not be affected due to either declining to participate or taking part.

Other gatekeeping practices were considered essential for accessing potential participants within the NHS and lecturers. For example Practice Learning Facilitators who support NHS mentors, university senior staff and NHS managers were required to give permission on access to disseminating invitations to participate in the study. All of these people were informed about the study and were given opportunities to ask questions in order to make an informed decision about access. Similar to students, it was possible that lecturers and mentors may have felt obliged or coerced into taking part. Each senior person who helped with access and dissemination of invitation was informed about the choice to participate residing with individuals and not employers or managers. This was reiterated on the information sheets they received and the recruitment presentations (see 5.5.2.3 for further detail of recruitment procedures).

It is argued that consent is an iterative process and not completed once a form has been signed, the issue about consent was repeated (Mason, 2002) at the beginning of the interview and at the end, just to confirm consent was still given. This permitted participants to withdraw from the study if they chose, (Polit and Beck, 2012), up until the write up of data and cultivation of arguments commenced.

According to Koivisto et al. (2001), people in receipt of mental health services should not participate in research. However, as participants who have a mental health label are likely to have the capacity to consent, due to being able to undertake a pre-registration programme, it was felt that this view was not appropriate in this context. In the unlikelihood that a participant was not able to maintain consent or potentially experienced coercion, each person was asked some questions at the beginning of the

interview with regards to their understanding of the research (Tee and Lathlean, 2004), to ensure consent was informed and secure.

5.6.2 Beneficence and non-maleficence

The ethical principles of beneficence and non-maleficence assert that the benefits of the research should outweigh any potential harm to participants (Beauchamp and Childress, 2009) and therefore justifying that the study can take place. The intended benefits are to improve the experiences of students diagnosed with a mental health condition before or during their pre-registration education and enable higher education institutions, placement partners and NMC to ensure best practice for supporting students with mental health conditions. As a consequence of taking part, Kvale (2007) asserts that some people may find the interview experience a positive one, as it illustrates the significance given to their lives. This was verbalised after the interview by two students, who felt silenced during their education, but also wanted to enquire further about potentially being able to access reasonable adjustments.

Qualitative methods such as interviewing necessitates a high degree of trust and therefore requires researchers to pay attention to and ensure trust is not abused (Mason, 2002). To ensure trust, no participant should suffer harm as a result of taking part (Denscombe, 2010). Prior to data collection, I was clear that the research would not result in physical harm, but the nature of interviews and the sensitivity around the topic was of concern.

During the research design and development of the interview schedule, ethical considerations were extended to the causation of emotional discomfort. This was especially pertinent when ensuring the interview questions were not intrusive or touched on sensitive issues (Denscombe, 2010). Considering the interview questions were regards to understanding of certain concepts rather than experience, emotional distress was not likely, but possible. Therefore, during recruitment, potential participants were asked to think about how taking part may affect their own mental wellbeing. Participants were informed at the start of their interview that their

wish to pause or end the interview would be respected. Only one student experienced emotional distress in response to a reflection about their experience of discriminatory practice during their education. The student was given the opportunity to stop the interview or rearrange for another time, but once composed, chose to continue as she wanted her experience to be shared, hoping it would not happen to others.

At the end of the interview, participants were presented with a debriefing sheet. This informed participants that they were able to talk to the mental health workers at the disability office who had an understanding of the study, but no knowledge of who took part. As participants may choose counselling external to the university, a list of local counselling services was included on the debriefing sheet, along with information regarding the methodology, further reading and contact details if they had any complaints.

People may experience mental ill health due to a traumatic experience (Morrison, 1998). Therefore it was possible participants may share a traumatic experience during the interview. For my own wellbeing, various outlets including my own supervisors or external counselling services were noted prior to interviews, just in case emotional support was required by me. However no participant shared any personal information which may have caused harm to self.

Other measures were put into place to protect those involved. For instance, anonymity and confidentiality was considered crucial. According to Polit and Beck (2012, p.162), *'A promise of confidentiality is a pledge that any information participants provide will not be publicly reported in a manner that identifies them, and will not be accessible to others'*. Gaining trust and making sure participants understood how their identity will be protected outside of the interview was essential. All potential and actual participants were informed about how information was collected and managed, so to ensure confidentiality (de Vaus, 2001).

Participants were informed about the audio recording of the interview at the recruitment stage and just prior to commencing the interview, including how they were going to be stored securely. All identifying features like contact

details etc was stored on a different password protected computer. Once recording were transcribed, they were informed about them being securely destroyed and that transcripts were kept on a secure computer. No other person had access to these documents.

All participants were informed that confidentiality would be maintained unless any disclosure of practice deemed unsafe by the NMC (2010a) would warrant sharing information with my supervisors. This information was disseminated on the information sheets, consent form and just prior to the interview starting. At interview, participants were informed that if concerns arose, I had a responsibility to stop the interview and give the reasons for doing so. As no questions were specifically targeted at nursing or midwifery practice, it was understandable that no concerns arose during the study.

Anonymity is a principle which ensures the identities of participants are unknown to anyone other than the researcher (Streubert and Carpenter, 2011). To ensure anonymity was safeguarded, various measures were put in place. The process of anonymity began at the recruitment stage as no contact details or demonstrations of interest were asked for during information sharing sessions. Potential participants were informed that all details of the study were available online, which allowed potential participants to view the information in privacy, without giving their peers any indication of interest. When small groups of lecturers and mentors were presented to, all group members were given an information sheet rather than expect people to identify their interest at that time.

For people who agreed to participate, ensuring anonymity was essential when choosing a venue to host the interview as I did not want people to be recognised by colleagues or peers when turning up for the interview. One venue among many was the university, whereby anonymity could not be guaranteed. Each participant was given a list of potential venues and times to choose from and asked to consider their anonymity. Providing various venues and times were also to ensure participants lives were not intruded upon. Most participants chose to be interviewed in rooms available on

campus, usually during office hours. These rooms were booked prior to interview to ensure no interruption.

Considering there is much discrimination and stigma attached to mental ill health, it was possible participants could experience negative consequences if anonymity was compromised. Therefore careful consideration was undertaken to ensure anonymity, especially as the study was small in size and local. Participants were informed about the exclusion of identifying features in any written work or supervision, as I didn't want people to be recognised in the data. This included the use of pseudonyms and codes for participants' names on within the interview transcribed. Any other identifying features were also changed like job roles, placement names or locations. Thick descriptions to support and verify dominant discourses are important to the meaning of the study, but the right to anonymity was respected. Language used specific to an individual was omitted from the findings and discussion chapters. As nursing and midwifery is still a female dominant profession and that some male participants took part, it was felt that writing up the demographics including gender differences of the sample would not ensure anonymity for some participants. Therefore no demographic information was collected.

5.6.3 Ethical issues

The research proposal was approved in two stages as data collection was conducted in both the university and clinical setting. The universities ethics procedures was administered first as the NHS ethics decision was partly contingent on the university's ethical approval.

The university ethics committee raised some issues around the provision of information regarding the methodological approach. Initially information given to participants about it being a critical discourse analysis project was going to be excluded. However, the ethics committee considered this essential for people to make an informed decision regarding participation. I presented my concerns regarding this request to the ethics committee, as I felt that this information could inform participants about the importance of

language use. This view is supported by Kvale (2007) and Robson (2011), in that omitting some information is justified as divulging it would cause participants to change their behaviour accordingly which could affect the data. For this reason it was agreed that the information sheet would include 'peoples' understanding and talk of mental ill health…' (see appendices, 2-4), but would exclude the words 'critical discourse analysis'. However, it is recognised that sharing this key information with participants could have affected the quality of the data.

During data collection within the university setting, an application for NHS ethics shortly followed. This was a long process, partly attributed to the number of clinical managers needed to give permission for this research project to commence due to two different professions across multiple NHS sites. In total, four managers were needed to give permission. Due to busy schedules, this proved difficult but was achieved.

Once submitted, a concern about one of the interview questions was raised. The interview question: 'What is your understanding of mental ill health generally?' was considered too vague and could have resulted in a variety of responses. However, I asserted that the intention of the study was to gain an understanding how people constructed the concept of mental ill health which may have resulted in differing responses. This was accepted and ethical approval was given.

Finally, ensuring anonymity has always been an ethical priority, but some findings have created a conflict between recounting dominant discourses and protecting the identity of participants. Some parts of the data proved to be significant in presenting a pertinent point but the quote was worded in a way which made the disclosure of participant potentially known and therefore was excluded from the study.

5.7 Research quality

It is imperative that any kind of research can stand up to scrutiny and be able to defend its conclusions in order to make it credible. This can be addressed by demonstrating trustworthiness via concepts of reliability and

validity, commonly associated with a positivist paradigm. Positivists customarily refute the trustworthiness of qualitative research as the approach makes it is impossible to ascertain the real world from interpretative methods, thus making it unscientific (Morse, 1999), a position firmly rejected in this study.

Conversely, there are no agreements about assessing the quality of qualitative research therefore the responsibility is placed on qualitative researchers to carry out research which is deemed worthy. It is suggestsed that this chapter has demonstrated the trustworthiness of research as I have been able to show the reader that I did everything feasible to certify data was collected, analysed and presented consistently, accurately and ethically (Yardley, 1997b; Denscombe, 2010), thus presenting methodological and interpretative rigour (Lincoln and Guba, 1985). I will present four criteria suggested by Lincoln and Guba to evaluate the quality of research. These are credibility, dependability, confirmability and transferability as an alternative to reliability and validity.

5.7.1 Credibility

Credibility is perhaps the most significant criterion in ensuring this research is trustworthy, appropriate and believable (Lincoln and Guba, 1985), as judged by the reader (Yardley, 1997b). This is similar to internal validity, whereby the research was able to investigate the phenomenon it intended. This study set out to investigate the discourses utilised by students, lecturers and mentors around mental ill health, reasonable adjustments and fitness to practice standards and how they influence a student's ability to reach their full potential. To achieve this, I have attempted to demonstrate that what is presented is a transparent commentary of the phenomenon under investigation, by presenting an accurate account of the research design, execution and discourses identified within written and verbal data collected.

To ensure credibility of this study, an awareness of my personal experiences was at the forefront throughout. Despite reflexivity, it is acknowledged that my disability experiences will have contributed to how I

designed the research study and considered some data more relevant than others. It was important to have other people involved during the research design stage and especially to cast an overview of my interpretations of the data. My academic supervisors played a key role in asking the why and how questions when reading through my work.

As a disabled researcher, it was not only important to present an accurate, effective and consistent piece of work, but it could be validated by other disabled academics. Consistent with critical realism and critical discourse analysis, it was important that the design and execution of the research could move towards the emancipation of disabled students. Therefore the contribution of experts by experience was fundamental (see 5.3). Their involvement provided insight into how the interview questions could be more appropriate, relevant to the sample population and have the ability to address the research questions.

Conducting the documentary analysis first gave an insight into the policy and guidelines participants were expected to ascribe to. This knowledge allowed probing questions to emerge. Using both documentary analysis and interviews of participants with different roles within nursing and midwifery education allowed the triangulation of data. The use of two methods has increased credibility as the various data and relationship with the wider literature has reduced the risk of bias (Wodak and Meyer, 2009).

The interviews were able to identify multiple realities and interpretations among participants. To ensure credibility, participants were asked to explain further the language used and the significance of what was being said. Where necessary, inconsistencies were followed up (Kvale, 2007) which enabled contradictions to be analysed as misunderstandings or legitimate interpretations of the participant.

A review of the interview questions was conducted after each interview. I would listen to the interview to enable an evaluation of my interview skills and how I could develop them further. This included looking at the language I used which could have influenced the participants' responses (see 8.4. limitations of the study for future discussion). This process was able to

identify one question which needed to be reworded to reduce confusion over what was being asked.

5.7.2 Dependability

Dependability is similar to reliability in that it refers to the extent research findings can be replicated, if a similar research project was undertaken. Reliability is not an orthodox concept to qualitative research (Gray, 2009) as it is difficult to achieve due to the contact between the researcher and researched is not replicable (Robson, 2011). Lincoln and Guba (1985) suggest dependability is more appropriate for qualitative studies. To achieve this, confirmation that an attempt has been made to present an account which affects the stability of the findings. For instance, measures were put in place to enhance dependability including a thick description of the research design, as demonstrated in this chapter, so the potential for some replicability is attainable (Gray, 2009). This includes information relating to participants, data collection methods, approaches to data analysis and issues that arose during the process.

All interviews were consistently audio recorded and transcribed verbatim, which provided a dependable representation (Cameron, 2002) and enhanced reliability (Robson, 2011) rather than relying on field notes which alone would not provide an accurate account of the interaction between myself and interviewees. It is important to note here that as part of my disability support allowance (DSA) (see 2.11.1 for a description), the audio recordings were sent to an independent transcriber. All transcripts were checked for accuracy once received. Also the findings chapter presents contextual detail with full and in some cases long excerpts of the data so the reader can make an informed judgement of the quality of the data. To aid a reflective account of the study, and to reduce researcher bias, the findings were shared with my supervisors who provided similar and somethings conflicting interpretations of the data.

5.7.3 Transferability

Validity can be achieved through demonstrating the trustworthiness of the research and the extent the research findings can be generalised. The intention of qualitative studies is not to achieve generalisation due to the presence of multiple meanings (Seale, 1999) owing to the constant fluctuation of social reality. The research design has enabled the research questions to be addressed, but sample size and the context of nursing and midwifery education disallows the reader to apply generalisations to other situations or populations. However Lincoln and Guba (1985) posit that qualitative studies can achieve transferability. Considering my subjectivities moulded the research, I have provided thick descriptions of the research design, process and situational context with the intention of making transferability judgements possible. This is so the reader can evaluate the applicability and decide if the findings can justifiably be relevant to other settings (Seale, 1999; Denscombe, 2010). This has been achieved by moving back and forth between research design, data collection and analysis so the progress and findings can be validated (Meadows and Morse, 2001).

5.7.4 Confirmability

Confirmability, a criterion of neutrality (Lincoln ad Guba, 1985) is a position completely unobtainable in qualitative research as the study will never be free from my influence. As previously discussed I bring a particular analytical lens which creates a bias (see 1.4 for my personal statement).My personal biography and political position around disability (see 5.4 for further discussion) would have influenced how the data was collected and analysed. It is argued that having a disability lens provides a specific interpretation of the data (Burr, 2003).

Patton (1990) argues that the researcher can demonstrate a neutral non-judgemental stance. This was achieved by demonstrating what Patton (1990) refers to as empathic neutrality. An empathic and therefore non-

judgemental approach to participants' responses was paramount irrespective of my own beliefs and interpretations at that time. Throughout the analysis, all participant responses and written text were critically examined in the same way and given the same attention. As a result, it is argued that a balanced representation of the findings, in line with the research questions has been reported.

Writing a reflexive journal has enabled me to identify times when my own personal experience may have influenced the research design and analysis. For instance, I was aware of how I responded to some parts of the data and not others and made sure this was attributed to it disconnection with the research questions or infrequency within the data. I was also aware that my interpretations may have at times been dissimilar to participants' intentions. For example, a student participant who expresses a view which they saw as typical and an accepted part of their educational experience, while I interpreted it as discriminatory. While both accounts are valid, thick descriptions and quotes from transcripts have been presented in order to show the reader why I have analysed the data in a specific way. This will allow the reader to make their own judgements and interpretations.

Finally, Lincoln and Guba (1985) suggest a confirmability trail which intends to document all of the data, how it was obtained and stored. To ensure all the data collected can be evidenced, a detailed account of participant interviews, how they were recorded and managed has been documented and could if necessary show an audit trail.

5.8 Conclusion

This chapter has presented a comprehensive account of the research design, data collection methods and how the data collected through documentation and interviews were analysed. The chapter has not only provided a description of the involvement of experts by experience but how they made a valid contribution to the trustworthiness of the study.

The chapter has detailed the sampling process that were utilised in order to recruit participants. This included the inclusion and exclusion criteria. Detailed accounts of the recruitment procedures and ethical considerations have been presented. The ethical issues and recruitment difficulties suggests that conducting the study was not always an easy task. The chapter has been able to illustrate the ethical and recruitment changes and adaptations made were appropriate and justified as they allowed the research questions to be maintained and addressed.

To add to the quality of the research, a description of measures taken to ensure the study can be substantiated by other people has been presented. A discussion on how credibility, transferability, dependability and confirmability is described in detail in order to allow others to make an informed judgement about its trustworthiness. The next chapter will present the findings from the employment of both documentary analysis and participant interviews.

Chapter 6: Findings

6.1 Introduction

This chapter engages with the research questions by investigating the dominant discourses illustrated in both participant interviews and documentation data sets. The study has identified three dominant discourses; the first being medical discourse, followed by a discourse around difference and finally a discourse around blame. Within each of these discourses, further discourse strands will be illustrated by using direct quotes from the data. A discourse strand is part of a text that refers to a particular topic and flows from a discourse which is more abstract and at the centre (Jäger and Maier, 2009). These will display how their intricacies influence participants and texts conceptualisation of student mental health, reasonable adjustments and fitness requirements. Each quote will be referenced in relation to the data set they have been generated from and allocated a number. For instance, student interview 1 (Si1), lecturer interview 4 (Li4), Mentor interview 2 (Mi2), University under investigation document 3 (U3). The NMC documents will be referenced with NMC followed by year of publication (e.g. NMC, 2010) (see appendix 10 for the documents list).

Consistent with discourse-historical approach (Reisigl and Wodak, 2001; 2009), the lexical choices, discursive strategies and argumentation schemes used will be linked to dominant discourses. This intends to identify how such usage leads to the construction of student mental ill health within the context of nursing and midwifery education (see 4.6.7.1 for discussion on discursive strategies). The analysis below will not only draw attention to explicit verbalisations, but also those latent and manifest utterances, whether consciously intended or not by the speaker or writer (Jäger and Maier, 2009). Furthermore, the discourse immanent critique which identifies inconsistencies, contradictions and dilemmas and the socio-diagnostic critique which identifies persuasive, populist and manipulative aspects of

discursive strategies have been presented (Reisigl and Wodak, 2001; 2009) (see 4.3.7 for a comprehensive discussion). Although this study is concentrated on mental ill health, it is not limited to it as other disabilities have transpired within the data sets. Each discourse is explained and will be explored further and linked to the wider literature in Chapter seven.

The diagram illustrated in Figure 1 below, will accompany the findings in order to demonstrate the dominant discourses and their discourse strands identified in both written and verbal text. This diagram will be utilised and expanded on in the discussion chapter to demonstrate how the discourses link and influence a student experiencing mental ill health during their nursing or midwifery education.

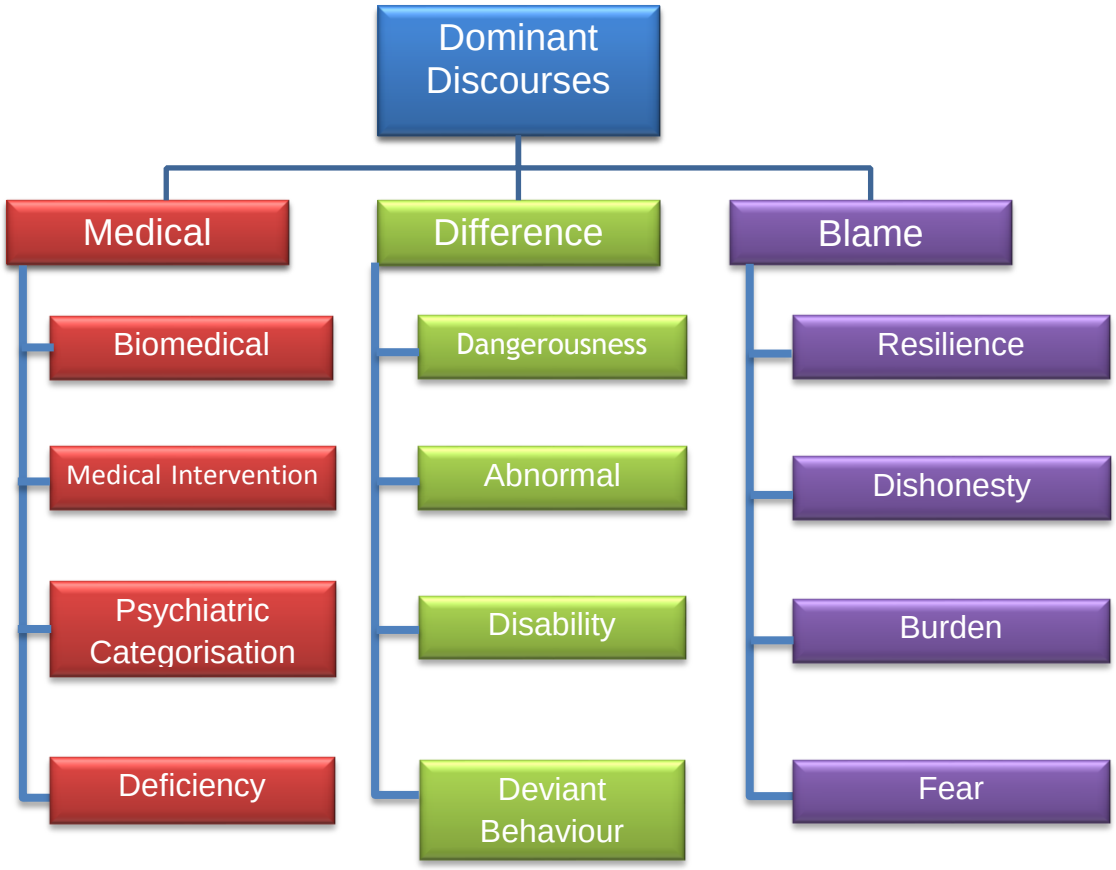


Figure 1 – Diagrammatic representation of the dominant discourses and discourse strands

6.2 Medical discourse

Both participants and documentation have illustrated how written and spoken language have mutually formed and reinforced an underpinning dominant medical discourse. This permits talk and text to focus on the medical condition as the cause of the student's disability and subsequently mitigating any social or environmental factors (Oliver, 1990). Below, the dominant discourse strands of medical discourse will be presented.

6.2.1 Biomedical discourse strand

Language used by interview participants when making references to mental health were dominated by an underpinning discourse of biomedicine. For some participants, it was an immediate response to the interview question regarding their understanding of mental ill health as demonstrated in the two excerpts below.

> "...your brain kicks into that fight or flight mode far too soon and it's the effect of adrenalin and things like that isn't it?" (Li25, page 3)

> "I understand that it [depression] can be a combination of chemical and psychological factors, it might be erm, a depletion of neurotransmitters…" (Si2, page 2)

The first excerpt indicates how the lexical choices 'your brain kicks into that fight or flight mode far too soon' suggests mental ill health has a biological cause. This is followed by the words 'isn't it ?' suggesting some reservation and a need for confirmation from the listener to legitimise the statement (Reisigl and Wodak, 2001). The student's understanding of depression in the second excerpt is also underpinned by biological causal mechanisms as demonstrated by the words 'a depletion of neurotransmitters'. This reinforces a particular ideology within medicine that suggests something

deficient in the brain. Both participants were unsure about the meanings of the biological terms used. However it does demonstrate how biological terms can be utilised without full comprehension.

The lecturer below also utilises a biomedical discourse strand. Similar to the previous excerpt whereby the student expresses their involvement in the discourse with 'I' and the lecturer's use of the word 'me' (Reisigl and Wodak, 2001) is a common lexical choice which has been demonstrated throughout the findings. This suggests an idiosyncratic understanding of mental ill health within nursing and midwifery education.

> "Mental health disease is to me when you are at odds with your environment." (Li15, page 3)

The word 'disease' illustrated in quotes above suggests biological causation. The use of the word 'environment' advocates a social dimension which interacts with a biological dimension. However the premise of the utterance is person-centric and underpinned by a discourse of blame, as it is the person who is at 'odds' with the environment, rather than the presence and influential nature of environmental elements. Blame will be discussed below (see 6.4 for further examples). A counter-discourse has also been verbalised with regards to depression by suggesting:

> "…it's not a disease but like a long term struggle." (Si13, page 3)

Firstly, to say something is 'not a disease' suggests it is considered a disease by others and the student is implicitly illustrating a disagreement with biological causation. Their lexical choice of 'struggle' is linked to experience rather than any biological attributions. This however is not suggesting experience excludes the use of biological discourse as the student who mentioned 'a depletion of neurotransmitters' illustrated above also shared his/her own experience of mental ill health. Even though mental ill health here is a counter-discourse to biology, the emphasis still lies with

the student's difficulty with mental health rather than a 'struggle' influenced by social factors.

6.2.2 Discourse strand of medical intervention

What is consistent throughout documentation and interviews irrelevant of participants' experience of mental ill health or not, was the underpinning discourse of medical intervention, this suggests a mental health condition requires medical treatment to cure it. An additional way of linguistically reinforcing a medical discourse was by the use of the word 'diagnosis', a lexical choice demonstrated by numerous participants, predominately in the context of aiding definition or justifying educational and pastoral support. The word 'diagnosis' contextually requires some sort of medical intervention indicating a process whereby human conditions require identification (Corrigan and Penn, 1997). The quote below reinforces the conception that a mental health condition not only needs diagnosing, which reinforces a medical discourse, but also suggests a mental health condition seen as different, constitutes the whole person, leaving any other aspect peripheral.

> "It kind of defines an individual that need diagnosing…" (Si20, page 4)

The excerpt below demonstrates how an immediate response to mental ill health is the expectation of diagnosis. The dominance of such a discourse is demonstrated by the use of the word 'obviously' which suggests common and accepted knowledge.

> "Well obviously something that's got a diagnosis for a start off." (Mi22, page 4)

The reliance on medical discourse demonstrates the utilisation of the argumentation strategy *appeal to authority* (Reisigl and Wodak, 2001). This reinforces the conclusion that specialist knowledge currently only attainable from the medical profession is superior to the students knowledge of one's

own mental health. This is also reinforced in the following excerpts from an NMC document and a lecturer.

> "[the student]…should submit a formal assessment of their condition and specific needs, from a GP or other medical or recognised authority…" (NMC, 2009, page 14)

> "…they [students] go for their assessment, they are given a diagnosis." (Li6, page 6)

Contextually these excerpts contribute to the process of drawing up a Learning Support Profile (LSP) (see 2.11.1 for a description of a LSP). These suggest a direct link between medical intervention and anti-discriminatory educational practices. What is also pertinent is how the power held by the medical profession is made explicit as their involvement is required before any adjustments can be implemented. It is the medical professional who has the authority to 'give' a person a diagnosis, linguistically referred to as something which can be brought by the student to the educational setting. It can also be argued that this dominant discourse reproduced by both the NMC and lecturer simultaneously has the power to ascribe the role of patient and create a dependency on the medical profession. The utterance below also demonstrates the power of medical discourse as the student is dependent on professional intervention in order to be accepted as a person in need of adjustments. The power is extended to the disability office whose role it is to assess students academic access needs.

> "…that's why I've emailed the LDU [Learning Development Unit], they've asked me to get erm, a letter from my GP." (Si10, page 5)

The student demonstrated confusion between the university departments in that the LDU is a service which supports all students in critical writing skills.

It is believed that the context of this utterance is regarding the Disability Office, as the LDU would not have any need to request a letter from the student's GP. The priority here is following the process of gaining expert knowledge and mitigating educational inaccessibility or the student's idiosyncratic knowledge. Furthermore, the powerful dominant medical discourse makes students adopt the patient role even in a university setting, a position reiterated by other participants within the study.

The power of medical discourse is most strongly presented in the anecdotal utterance below. The student's disclosure and unique understanding of depression is dismissed until it has been acknowledged and documented by a professional.

> "…if they [students] said I've got depression, I have depression, I would go, how do you know that? Where's that from? You know, do we know that, is that recorded? [by the university]." (Li15, page 10)

The lecturer not only demonstrates how medical discourse is dominant and used to legitimise the student's claim, similar to previous excerpts, but also how a the presence of a medical diagnosis which is recorded means the student can be believed. Furthermore the lecturer's priority has dismissed the responsibility taken by the student and mitigated any potential harmful effects of depression.

Finally, a discourse strand of medical intervention is reiterated by the university's fitness to practice procedures. Amongst the number of concerns educators can have during fitness to practice investigation is the students decision not to seek medical treatment.

> "…include concerns about a student's: health and wellbeing, including failure to seek appropriate medical treatment…" (U1, page 3)

The statement reinforces the power held by the dominant group; the medical profession and potentially against the interests of the non-dominant group; students. The use of the word ‘failure’ is a persuasive predication strategy employed to place blame onto the student if no medical intervention is accessed. (see 6.4 for further discourses of blame). A topos of responsibility is utilised (see 4.6.7.1 for further discussion on topos), suggesting the responsibility lies with the student, therefore mitigating the responsibility held by the lecturer. Also it discursively disallows other factors to be considered like the unavailability of medical intervention. Finally, a predication strategy is employed by the use of the word ‘appropriate’ suggesting that some alternative medical treatment or non-medical treatment may be deemed as inappropriate by the university under investigation’s fitness to practice panel, suggesting subjectivity. As previously stated and repeated throughout the study, the causal mechanisms of mental distress is exclusively medical, thus justifying the omission of any social structures which may negatively influence a person’s wellbeing.

Similarly, a student verbalises an example of a reasonable adjustment which permits the focus onto the student, allowing other disabling practices to go unnoticed. Not only does it suggest therapeutic intervention is intertwined with reasonable adjustments, but also assumes the person experiencing mental ill health will need, want or benefit from therapeutic intervention. Secondly, the counselling service within the university can be accessed by any student or staff member and does not correspond with university and NMC policies.

> “…things that are put in place like in case like counselling to be put in place if they need it…”
> (Si20, page 6)

6.2.3 Discourse strand of psychiatric categorisation

A discourse strand around psychiatric categorisaton, was revealed through the language use mainly in the interview data set, when participants were

asked to talk about their understanding of mental ill health. For most, they were referred to prior to any description of mental ill health.

> "The sort of things that we tend to see in students are things like anxiety, depression, OCD, those sorts of things." (Li12, page 5)

> "…bipolar and things like that." (Li25, page 3)

The unquestionable and self-evident pathological constructs are demonstrated above with the use of the abbreviations 'OCD' (Obsessive Compulsive Disorder) and 'bipolar' (Bipolar Disorder). Not only does this suggest how shortened terms are uncritical and discernible constructs, assumed to be common knowledge, but how psychiatric hegemony can typify students. These lexical choices are not only indicative of their ideological stability, but their dominance suggests how mental health conditions can be over-simplified, used to collectivise and position the individual in the background, therefore dehumanising mental ill health.

In addition, within the first excerpt, the use of the word 'we', suggests that the lecturer and colleagues are aware of student mental ill health and is evidenced by the use of topos of numbers which emphasises the commonality amongst nursing and midwifery students. It is important to note this will be discussed elsewhere in relation to a dominant counter-discourse asserting the scarcity of students experiencing mental ill health, used to justify the rare existence of reasonable adjustments (see 6. 2.4). Analysis of the word 'we' also demonstrated in the excerpt below suggests the ability of speakers to distance themselves from people who are considered mentally ill by associating mental health labels solely with students. While the lecturer illustrates the student at the start of the utterance, the person disappears and is replaced by the condition.

> "…anxiety and depression with students yeah… and we've also had a very occasional psychosis…" (Li7, page 3)

Other dominant psychiatric categorisations have been utilised including Schizophrenia. This word was frequently mentioned, but when participants were asked to clarify what they meant by the word, various evaluative strategies were deployed.

> "Schizophrenia is a personality disorder and I would be very surprised if anybody really with schizophrenia could function as a nurse…" (Mi22, page 6)

Firstly, making reference to schizophrenia and personality disorder in the same sentence reinforces the stereotypical view that they are one of the same things. Secondly, the word 'surprised' mitigates the negative fallacious generalisation that all people with this psychiatric label would not be able to practice as a nurse. The claim reinforces the stereotypical prejudice by alluding to a whole group and forming a connection with an inability to practice. Simultaneously, as a practicing nurse, the mentor employs an argument from personal incredulity which legitimises the claim that no nurse has a diagnosis of schizophrenia because the mentor cannot consider it true. Finally during the interview, the mentor verbalised that having a mental health condition and practicing as a nurse can coincide. Therefore it can be argued that the reference to 'schizophrenia' suggests the label forms part of a hierarchy of mental health and is placed quite low on a metaphorical spectrum of the mental health labels nurse and midwife practitioners can present during their career.

The use of the words 'personality disorders' have been referred to by other participants when listing mental health labels, but it can be argued that participants are ambiguous about this term. For instance the following student alludes to multiple and split personalities, but uses the word 'person' rather than personality, suggesting two human beings in the one person.

> "…personality disorder, erm, how would I describe it? Just like two different person's in one body…" (Si13, page 3)

The discourse strand of psychiatric categorisation has also been illustrated by educators below who demonstrate confusion about labels associated with mental ill health and those associated with other disabilities, which indicate an uncertainty around mental ill health. However, similar to previous excerpts of psychiatric labels, the discourse reinforces categorisation and collectivisation of the nursing and midwifery student population.

> "…I don't know if it's a mental health issue, is dyslexia, I'm not sure." (Mi23, page 4)

> "In the whole years [10] the only student that I have had, and I'm not really up on mental health, but whether it is classed as one, I had a student who had Asperger's." (Li6, page 2)

In the first excerpt, the mentor employs a predicational strategy which serves to emphasise ambivalence around student disabilities which can be argued to have a detrimental effect on a student's learning and assessment if understanding is absent. The second excerpt also demonstrates an uncertainty about language underpinned by a discourse strand of medical categorisation. However, the use of an argumentation scheme allows for conjecture, therefore legitimising the lack of knowledge on mental health. The lecturer also explicitly refers to categorisation with the use of the words 'classed as one'. What's more is the utterances suggest a gap in the educators knowledge which has not been filled during their teacher or mentor training.

6.2.3 Discourse strand of deficiency

Within the documents and interview data sets appeared an underpinning discourse strand of deficiency. This predominantly manifested when reasonable adjustments formed part of the text and the focus was on the student's disability, rather than external factors. The excerpts below illustrate how this discourse is employed by both educators and students through the frequent use of the word ''extra', typically followed by the words 'support', 'time' or 'help'. These words have been used to aid definition of reasonable adjustments. For instance, the immediate excerpt below demonstrates an example of a reasonable adjustment given by a lecturer.

> "…within the university it might that they are given extra support…" (Li18, page 5)

Firstly, the verbalisation emphasises the university environment, therefore mitigating any suggestion that adjustments are not relevant during clinical placements. The excerpt presents an ideology which suggests students need something extra, reinforcing the stereotypical generalisation that a student is deficient in something and requires something supplemental. The focus directs the attention away from evaluating university and NHS practices and structures in order to eradicate structural barriers. Furthermore, the lexical choice of 'given extra support' suggests another person or people are required in order to create an inclusive learning environment, which reinforces dependency and difference. The verbalisations below not only illustrate the dominant lexical choice of 'extra', but how it has contributed to varied interpretations of reasonable adjustments.

> "Reasonable adjustments might be in relation to extra academic supervision, extra time for assessment work…" (Li17, page 7)

This excerpt demonstrates a need for extra time which allows a discourse of additional need to solely reside with the individual student. Similar to the previous excerpt, reasonable adjustments is synonymous with academia. While assessment work may refer to the clinical environment, it is still focused on needing additional time to write, which excludes adjustments to aid positive patient interaction. The assertion of extra time is not shared by all lecturers within the same faculty.

> "…they don't get extra time for assignments…"
> (Li6, page 8)

Extra time for assignment work is predicated as incongruent with reasonable adjustments. No argumentation strategy was established within the interview, as it was presented as fact rather than a personal understanding. Irrespective of the tone, it demonstrates the practice of reasonable adjustments is inconsistent throughout the nursing and midwifery faculty, indicating subjectivity. Regardless of the multiple evaluations, the word 'extra' intensifies the stereotypical assertion that students considered disabled are given special or favourable treatment. It can be argued that this reinforces an ideology that reasonable adjustments will always be necessary if a disability exists. Subsequently, this enables the mitigation of any argumentation indicating environmental and social barriers and draws attention to the perception of inability or deficiency.

The dominant discourse strand was demonstrated by another lecturer whose immediate response to student mental ill health is to advise intercalation. Again the focus is on the students' disability which results in the student's education being suspended.

> "Well I suppose reasonable adjustments would be things like providing extra opportunities to meet and talk to erm advise things like intercalation, if the student's experiencing a period of stress…" (Li19, page 8)

As no other examples of reasonable adjustments have been illustrated in the interview, the lecturer considers her role as reactive rather than anticipatory. The word ‘advise’ suggests a perspectivation strategy whereby the lecturer positions self as a person able to tell a student what they think they should do, based on personal or professional experience and power. Not only does this reinforce a discourse which results in rehabilitation, but the lecturer assumes the student is seeking advice and therefore is deficient in decision making.

This ideological approach has the potential to reinforce an imbalance of power by constructing the student as a passive object, who is the victim of mental ill health and the focus of alteration. The absence of a discourse which supports the student to sustain their involvement in education reinforces the stereotypical generalisation that non-attendance of education is beneficial. Constituting adjustments in this way legitimises exclusionary practices of students, which then helps sustain the stereotypical predication that mental ill health amongst the nurse and midwifery population is considered unfit. Finally, the lecturer incorrectly categorises stress as a legislatively recognised mental health condition.

When students return to study, it is the role of the medical profession to ensure the student is medically fit, as demonstrated below. Consistent with utterances within the study, the lecturer employs a perspectivation strategy with the use of ‘we’ which serves to distance self from the practice described in the anecdote below.

> “She’s not, she hasn’t been assessed, we sent her to occupational health on her return to make sure she was fit to return, she had to get a fit to return note from her GP. Erm but she hasn’t had any reasonable adjustments.” (Li5, page 5)

It is possible that an occupational health assessment or fit to return processes serves to identify potential reasonable adjustments, but as the

lecturer states in the interview, no adjustments for mental ill health exist. Therefore the lecturers understanding of a return to work note is used to ensure the student is free from a disability, is fit to re-enter education and therefore does not require the university or NHS to make reasonable adjustments. Furthermore the lexical choice ‘sent her’ reinforces the lecturers’ power to instruct medical intervention without exploring environmental and social factors which may contribute to mental ill health.

An additional way of linguistically reinforcing a discourse of additional need has been identified within NMC policy. The excerpt below illustrates how this discourse is replicated within NMC policy.

> “Consideration should be given to allocating time for mentors, practice teachers and teachers to meet the special needs of students with disabilities.” (NMC, 2008b, page 18)

Students with disabilities are considered to have special needs which need to be met by educators. The lexical choice of ‘special’ reinforces the predication that students with disabilities are not only different to other students (see 6.3 for discourses of difference) but mitigates the discriminatory barriers within the NHS environment and therefore disallows any reflection on what could be changed in order to ensure inclusivity for all, and not just students with disabilities.

Whilst continuing with an interpretation of reasonable adjustments which reinforce a discourse of additional needs of the student, many participants illustrated an understanding inconsistent with equality legislation. The narration below is contextually referring to an experience during the third year of study. It is important to note, this student frequently disclosed their mental ill health to university staff and had not participated in any assessment for adjustments.

> "…I have been given chances to re-submit work
> if I needed to…" (Si2, page 5)

The student's intention is to illustrate a positive experience legitimised by the use of the word 'chances' which is a discursive exchange implying reasonable adjustments. The use of the word 'given' suggests a performative discourse as an object belonging to the educator, referentially called chances, is transferred to the student. This demonstrates how a lecturer has power over resources, in this context an extension. The student discursively legitimises a positive presentation of lecturers by the words 'given chances', which suggests that this opportunity was a result of the lecturer's empathy and judgement.

The verbalisation demonstrates a number of misleading assertions. Firstly, extensions are available to both disabled and non-disabled students and therefore cannot be referentially considered a reasonable adjustment. Secondly, as reasonable adjustments are a legal entitlement, this suggests that lecturers have the ability to 'give' a student their legal right. However, to give a person a 'right' is conceptually impossible as the 'right' already belongs to that individual. Therefore this verbalisation is able to demonstrate the perception of power possessed by lecturers and how this perception can reinforce and maintain power. The verbalisation also illustrates a negative presentation of self by presupposing the student's mental ill health is the cause of unmet deadlines. While this may be a cause, the verbalisation suppresses any other potential causal mechanisms reinforcing a discourse which focuses on the student.

The following verbalisations illustrate additional meanings attributed to reasonable adjustments for mental ill health. It is important to note the verbalisation below does not stem from experiential knowledge as the lecturer stated during the interview that no students experiencing mental ill health was known to them during their long career in nursing and midwifery

education. The utterance is contextually referring to students who do not disclose their mental ill health.

> "…nobody can make allowances for the problem." (Li19, page 5)

The word 'allowances' is a persuasive metaphorical device that reinforces the stigmatising view, that reasonable adjustments exist due to the disabled person's inability to achieve the same as non-disabled peers. The word reinforces a discourse of additional needs through the supposition of concession which needs to be made for students with disabilities. As no examples could be extracted from previous experience, it can be argued that the verbalisation fulfils the function of evading responsibility, disguising the lack of adjustments and shifting the attention onto the student. As a result, any discursive realisation that discriminatory practices have been executed, have been extinguished. The verbalisation therefore permits the responsibility of educators to be condensed to the responsibility of the student.

Reasonable adjustments has also been attributed to enabling the student to 'overcome' their disability, which allows mental ill health to be anomalous and wellbeing considered customary, therefore justifying the need to return to a normative position.

> "But I think ultimately the support required, what's reasonable is to enable the student to learn to overcome erm their own issues… (Li19, page 6)

The use of the phrase 'learn to overcome' is a persuasive argumentation strategy which denotes a prejudicial perspective that the student can learn how to eradicate their mental ill health. The argumentation 'to learn' potentially legitimises the exclusion of students or qualified nursing staff who will continually experience mental ill health when reasonable adjustments are in place. Finally the lexical choice of 'own issues' indicates

a distancing technique whereby the 'issue' belongs to the individual and therefore not created or exacerbated by educative practices and structures.

The only excerpt identified in the study which links reasonable adjustments to disabling barriers experienced during placement is illustrated by the student below. Breaks during work time are a health and safety requirements for all nurses and midwives and not a reasonable adjustment. However, the utterance is still able to place the issue with environmental factors by suggesting the current practice exacerbates mental ill health and is therefore disabling.

> "That I get my breaks, that erm that's obviously that's for the mental health with the depression, one of my triggers is tiredness, to maintain that I get my breaks…" (Si14, page 6)

6.3 Discourse of difference

Throughout the study, students considered to have a mental health condition have been discursively talked about as different to others. This discourse has been re/produced both implicitly and explicitly within both data sets, but predominately through participant interviews. It is impossible to present an exhaustive indication of how a discourse of difference has been illustrated. However, the most frequent examples will be presented. Four underpinning discourse strands related to difference were identified and have been illustrated in the diagram above (see figure 2). This section will demonstrate the various ways a discourse of difference has been ascertained.

6.3.1 Discourse strand of dangerousness

Like many participants, presenting others through discourses underpinned by stereotypical ideology was revealed during narratives which were of

fictitious events. One dominant stereotypical trait has been verbalised both explicitly and implicitly by most participants and have persistently been followed by argumentative plausibility of unsafe practice. Patient safety is a strong hegemonic argument which is difficult to challenge as patient safety within any hospital care is pivotal and understandably so. However, the immediate link between mental ill health and unsafe behaviour or practice allows for the prejudicial discursive practice to further strengthen a discourse of difference. In addition it illustrates a counter-discourse to the previous excerpts which suggest stigma resides outside of nursing.

The lecturer's utterance below suggests the conflation of mental ill health and safety within nursing discursively permits people to assume dangerousness. The lecturer is able to distance self with the use of 'at least in some people's minds', which serves to mitigate any association with the discriminatory discourses.

> "I think there is, at least in some people's minds, the stereotype that mental ill health er automatically creates a question about competence or safety to be in practice…" (Li17, page 5)

The lecturer therefore positions the existence of discrimination within the university and specifically within nursing and midwifery education to reside with others. This perception is supported by many references around dangerousness both from students and educators. For example the utterance below demonstrates an argumentation strategy which serves to legitimatise disclosure of mental ill health. The persuasive discursive practice indicates a prejudicial ideology towards other students and qualified nurses and midwifes by equating mental ill health to unsafe practice.

> "But for the safety of patients and ourselves and who we are working with, staff around us, maybe it

> [mental ill health] should be disclosed…" (Si8, page 15)

The primary role of disclosure here reinforces the underpinning discourses which link mental ill health and dangerousness rather than than an event which promotes equality, combats stigma and is a catalyst to accessing adjustments. Disclosure is regarded as a moral obligation, rather than a choice made by the individual, legitimised by safety of patients and self.

A similar discourse was utilised when a lecturer was asked if the NMC good health requirements are clear to students who have a mental health condition. The lecturer suggested the definition was open to interpretation. This was preceded by the employment of both referential and predicational strategies which revealed a discourse of difference underpinned by dangerousness.

> "…nursing is full of people that clearly get through, we can list them by the Beverley Allitt's of this world that clearly get through nursing, erm that we don't see you know…" (Li15, page 17)

Firstly the lecturer declines to position self explicitly in the discourse with the use of 'we', making the social actor initially ambiguous and the stereotypical and prejudicial reference seem legitimate. Immediately prior to this quote, the verbalisation was regarding students who do not disclose their mental health condition and therefore are hidden from identification during their education. What became apparent was the immediate employment of a predicational strategy which linguistically indicates a stereotypical articulation commonly associated with people who have a mental health condition. A topos of history is utilised by referring to a criminal case over 20 years ago. The verbalisation suggests history teaches us that the actions of Beverley Allitt which had devastating consequences, justifies the comparison to student mental ill health.

The interview participant employs a fallacy of a *secundum quid,* a hasty generalisation by expressing covertly an insinuation that students who have a mental health condition are collectively different, dangerous and pose a risk to patients in their care. The scenario presented is not impossible per se, but the reality is exaggerated by adding a plural insinuation 'we can list them', even though a list did not transpire. A discourse of dangerousness was only discursively illustrated when students or registered nurses or midwives with mental health conditions were discussed. It can be suggested that an underlying assumption that non-disabled students and registered practitioners will always be safe to practice or will never commit criminal acts. Another participant was just as explicit, if not more so about their association between mental ill health and criminality.

> "…if nothing gets done about it [mental health], if they do something stupid, like kill someone or steal something…" (Si20, page 4)

The student employs an *argumentum de consequentium* fallacy which allows the conclusion of an undesirable consequence to be legitimised. This strategy reinforces a discourse of dangerousness by suggesting that people experiencing mental ill health who do not receive intervention will be expected to participate in criminality. The hegemonic nature of this stereotypical predication is demonstrated below firstly by a lecturer, but also a student who is referring to a reflection regarding a telephone interview with occupational health prior to being accepted onto the nursing programme.

> "I don't think there's an overall stereotype that mental ill health means axe wielding murderer." (Li17, page 5)

> "…nobody's dead and I've not run around the wards with an axe…" (Si3, page 5)

The examples both refer to an ‘axe’, suggesting a common stereotype is present. Both intend to present a counter-discourse to dangerousness by detaching self from this discriminatory ideology and mitigating its prevalence. However, while doing so, a discourse of dangerousness is still re/produced and maintained. Furthermore the dominance of such stereotype was confirmed by the student who following this statement, was asked if this predication was how others saw nurses experiencing mental ill health. The student was certain that this was a common predication.

The scenario presented below is based on a narrative of an event which previously happened at a different university to the one under investigation. This verbalisation demonstrates the employment of the fallacy *ignoratio elenchi*, an evasive strategy which serves to avoid a question being asked. The topic being discussed at this time was about the fitness to practice competencies students are expected to meet in order to succeed. It is unclear why this verbalisation occurred but it serves to verify previous prejudices around dangerousness with an isolated incident. Furthermore, a fallacy of innuendo was utilised as there was no suggestion this narrative was regarding a student who experienced mental ill health or no argument to support the claim.

> “So I once had a student for example, and again this wasn’t here, who managed to kill a patient” (Li18, page 12)

The excerpts below also demonstrate how a discourse of dangerousness is endorsed by the use of the *argumenta ad consequentiam* fallacy. The stereotypical ideology presented below, asserts that people who experience mental ill health legitimises suspicion and surveillance. This reinforces the power held by others who represent an anonymous group linguistically referred to here as ‘we’.

> “we need to keep cautious in case something happens” (Si20, page 4)

This was reiterated by the lecturer below who despite acknowledging that nothing untoward has happened with regards to a student who is perceived to have a mental health condition, allows an unsubstantiated predication to materialise. The lack of evidence in this assertion demonstrates the strength of a discourse which conflates mental ill health and unsafe practice, allowing for a discourse of dangerousness to prevail.

> "And yet nothing's happened, but I'm damned convinced something's going to happen…" (Li15, page 7)

A discourse of dangerousness was brought to the forefront by the same lecturer who at the start of the interview considered the lecturing role to be underpinned by a discourse of criminality, surveillance and punitive action. This was established by a similar argumentation via a metaphorical reference to 'policing'. Here the lecturer suggests policing is a role within their job description, indicating the perception of power the lecturer considers they hold. It is important to note here, that this lecturer considers the assessment of standards is a personal judgement, which suggests power held is open to interpretation.

> "…some role in what you might view to be a standard setting, there might be things like policing, so you're making sure that they are meeting standards…" (Li15, page 1)

It can be argued that this stereotypical ideology is reinforced by the NMC who indirectly link disability and health conditions to unsafe practice. The following statement begins with a clear indication that disability equality forms part of the NMC's duty. However the positivity is followed by a statement which allows disability and unsafe practice to discursively reinforce an underpinning discourse of dangerousness.

> "The NMC has obligations to advance disability equality…At the same time we need to ensure

> that we are meeting our legislative responsibilities of safeguarding the health and wellbeing of people using or needing the services of nurses or midwives." (NMC, 2010, page 7)

A counter-discourse was presented by one participant who suggested that an unsafe practice potentially dangerous towards patients has been carried out by all nurses. The premise of the claim is an exception within this study, therefore making an appraisal that unsafe practice can be carried out by any student or qualified practitioner minimal, while enhancing the legitimatisation that mental ill health equates to difference and unsafe practice.

> "…we've all made drug errors, I don't think there is a single nurse here that hasn't somewhere along the line made a drug error." (Li6, page 15)

6.3.2 Discourse strand of abnormal

A discourse strand questioning normality of people with mental ill health has been demonstrated by the use of the word 'normal', utilised a multitude of times throughout participant interviews. The lecturer below is describing a personal understanding of mental ill health. Firstly the lecturer employs a perspectivation strategy with the use of 'we', to represent the 'in-group' (van Dijk, 2001), referentially categorised as 'normal'. The use reinforces an ideological position that those who are members of this group have the power to categorise those who considered members of the 'out-group'. The lexical choice also asserts a hierarchy of mental health suggesting that some mental health conditions are further away from normalcy than others.

> "… it's a spectrum isn't it, from what we might consider normal." (Li12, page 5)

The lecturer below illustrates how a discourse strand of abnormal can have a connotation of capability. Here the narration begins with a negative

predication suggesting an inability to do what 'normal' people would do, therefore deviating from what is considered a social norm.

> "…not being about to carry out the normal things, that people do in their life…behave appropriately, do everything as would, I hate the word normal, but …."(Li7, page 2) "…I mean to manage a normal life…" Li7, page 4)

Simultaneously, the lecturer's use of 'normal' groups those people considered as capable, allowing for people considered to reside outside of normalcy to be predicated as incapable. Furthermore the lexical choices of 'behave appropriately' suggests inappropriate behaviour is inconsistent with a discourse strand of abnormality. However, it is unclear what is appropriate behaviour and who defines it. A discourse around behaviour has been employed by other participants and will be expanded on below (see 6.3.4). Finally, just prior to verbalising the word 'normal', the participant below also reflected on its use and expressed a dislike. It can be argued that this verbalisation was used to legitimise its continuation of use. The word was not only in this sentence, but at another moment in the interview, illustrated at the end of the excerpt, therefore demonstrating how its use supersedes any personal criticism.

A discourse of difference has been strengthened further by the lecturer below who considers his/her mental health literacy as competent. This serves to strengthen the false dichotomy fallacy, whereby only two predications are available; 'normal' and 'abnormal'. The lecturer's self-assessment of competence functions to present a persuasive argument and serves to legitimise the differentiation between people who do and do not experience mental ill health.

> "…my level of mental health is to a point of the competent person who can differentiate this is

> normal and this abnormal and do I need to refer you." (Li15, page 2)

The lecturer's employment of a derogatory predication through the use of the word 'abnormal' reinforces a discourse of difference and enhances stigmatising and discriminatory ideology. The lecturer's assumption that people experiencing mental ill health need some sort of intervention is also reinforced below by a student when talking about their understanding of reasonable adjustments. Both illustrate how a discourse strand of abnormal is entangled with a discourse strand of deficiency (see 6.2.3) which suggest an ideology whereby the interaction between interventions and the person considered mentally unwell have causal power to enhance the character of the person to meet social norms.

> "…they need some sort of special things put in place so they can feel normal in a way, or fit into society." (Si20, page 4)

The student linguistically adds to the previous notions of 'normal' by referentially asserting it as an emotion. In order to 'feel normal', the word 'special' is employed which serves as a rhetorical device of euphemism to describe intervention as a positive term. This allows for the mitigation of the negative predication that people considered mentally ill are outside of society. A counter-discourse is demonstrated by the same student when the social practice of adjustments is situated in the university setting, as illustrated below. A discourse of difference is maintained through claim of injustice underpinned by comparison, a rhetorical strategy which functions as an illustrative example that students experiencing mental ill health does not meet a subjective standard of normalcy.

> "…it is unfair in total to give people extra time compared to normal people." (Si20, page 9)

The discourse of abnormal has not only been established by people who placed themselves outside of mental health experience, but also students who have shared their own experience during their interview. The student

below is referring to treatment by mentors during placement. The context in which 'normal student' is used demonstrates how the student's use of a perspectivation strategy positions self outside of normalcy, therefore reinforcing a discourse of difference.

> "If you are like, they tend to go through with every step more than you do with a normal student." (Si13, page 5)

The link between reasonable adjustments and normalcy has been dominant throughout the findings. However the student below adds a different dimension to their implementation and influence on abnormality. The excerpt demonstrates a counter-discourse by suggesting the role of adjustments is to give the perception of normalcy. Therefore the needs of the dominant group to perceive normalcy in others is considered the focal point of adjustments, allowing the argument of inequality or discrimination to be silenced.

> "…for you to maintain (pause) a publicly percepted normal life." (Si14, page 4)

The need to be perceived as normal has been reiterated by the student below, illustrating the ideological dominance of normalcy amongst students who identify with a discourse underpinned by difference. However the excerpt below through a positive predication of a mentor on placement, demonstrates the discourse's hegemonic status by asserting a dichotomy of normal is attributed to mental ill health. The student's narration of the mentors observational skills reinforces a stereotypical ideology that mental health is observational and therefore illustrated to others through behaviour considered different.

> "…I were trying to sort of look quite normal, somehow she picked that out and I thought, actually you probably should be a mental health nurse, because you've picked that out just so spot on" (Si9, page 11)

The excerpts above all suggest a societal expectation of normalcy, a conjecture that people know what this term means and an assumption that we all consent to this ideological classification. When a person is considered to reside outside of this ideology, potential consequences may result. This was made more apparent in the excerpt below, which demonstrates how the lexical choices can be made explicit. It is important to note, the lecturer was referring to passport photographs of all students within nursing.

> "…me and one of my colleagues …we sort of looked at them and we keep pointing, that's her, because she's just got everything, she sits in the class isolated … she doesn't fit in, she even pictorially doesn't fit in…every other student's got something there, there's a smile, there's this stony face looking at you that puts a shiver down my spine…I don't know what year… but she scares the pants out of me. And yet nothing's happened, but I'm damned convinced something's going to happen…" (Li15, page 7)

Firstly, the lecturer employs a self-referential strategy. The lecturer linguistically demonstrates membership to the 'in-group' by making reference to a colleague. The discursive strategy serves to legitimise and strengthen the claim by presenting a shared view, while at the same time mitigating the personal nature of the discriminatory ideology held by the speaker. The additional social actors referred to as 'them' are students who are identified using the referential strategy of the negative other-presentation.

The excerpt when referring to appearance serves to justify the claim about anticipated practices which may result in unsafe nursing care. This presupposition is expressed with derision by presenting a chain of prejudicial stereotypes to the physical identification of the individual student,

legitimised through the *topos* of comparison to other students which reinforces a discourse strand of abnormality. The student is predicated as pictorially different as a result of discriminatory rhetoric. She is visually considered as the 'other', which functions as a negative evaluative discourse, allowing other students to be constituted as homogenous and socially acceptable. The utterances discursively construct a discourse of sameness underpinned by a discourse of normalcy, attributed to other students who are not considered to have a mental health condition. This acts as a form of exclusion which aims to set a person apart from others and reinforces the ideology that mental ill health is an undesirable identity. The language used also reinforces the stereotypical ideology that mental ill health is visible to observers by showing how she resembles what is considered to be behaviours of a person with a mental health condition. Such behaviours, presented here as flaws, rather than a demonstration of freedom to be an individual, are narrated as minutiae which when correlated make the *topos* of unsafe to practice more conclusive and deterministic.

'Stoney face', meaning emotionless and absent and 'shiver down my spine' meaning a physical feeling when faced with someone or something they fear are non-literal rhetorical devices. These allow for the projection of knowledge to be absent while reinforcing stereotypical and prejudicial connotations which arguably aim to legitimise the relationship between mental ill health and unsafe practice. These utterances and 'she scares the pants out of me' demonstrates a fallacious causal link between the student's physical appearance and behaviour and the lecturer's emotional response. The lecturer employs the victim-victimiser reversal strategy which enables the blame of causing fear onto the student. An alternative discourse which suggests a causal link between the prejudicial attitude of the lecturer and the emotional response is absent.

Evaluating a student from a distance not only allows the reproduction of negative mental health constructs, but simultaneously deprives the student the opportunity to have a voice which reinforces the silencing of students.

The lack of social interaction between the student and lecturer and the employment of the *ad hominem* argument, whereby an individual's appearance and character is discredited to justify the claim, makes it impossible to explore other options which may benefit the student's learning experience.

Another lecturer made a similar utterance by referring to students as 'very odd'. The referential word 'odd' not only is attributed to depression, but also to indicate a group of students dissimilarity to the majority.

> "we've had a number of very odd students, er, lots of students with depression"(Li5, page 7)

The word 'odd' can have multiple meanings but the lecturer's use includes a topos of numbers, suggesting 'odd' refers to behaviour considered different rather than a rarity of depression in the nursing and midwifery population. However it is important to note here, that a counter-argument has been emphasised by numerous lecturers, suggesting no students experience mental ill health, therefore legitimising the absence of adjustments.

As a means of determining eligibility for reasonable adjustments, the excerpt below demonstrates how the student is expected to adopt a discourse of difference by the use of 'declare'. This suggests an announcement that reinforces the re/construction of the student as 'other'.

> "Student who declare on application that they have a disability…" (NMC, 2009, page 14)

The word 'declare' is an extension of the discourse around abnormality in that the social practice of 'declaring' allows a distinction between students who are considered 'normal' and those students with a mental health label and other disabilities to prevail. The language use of 'they have a disability' intensifies and enforces a discourse of difference. The student is expected

to adopt an identity which may or may not correspond with a personal construction of self.

The excerpt below demonstrates how the word ‘declare’ was attributed to a prejudicial and stereotypical generalisation. The lexical choice of ‘when’ makes a predication that students with a mental health condition will be unfit at some point during their education.

> “So that’s why people are supposed to declare their health status and make practice aware when they’re unfit for practice...” (Li7, page 14)

The use of ‘suppose to’ also reinforces an assertion of obligation, placing the onus onto the student and mitigating any other factors that may prevent students from disclosing mental ill health. Furthermore the excerpts illustrates how informing others of mental health is firmly placed in a negative domain, allowing for any positive aspects of experiencing mental health to be silenced.

The distinction between disabled students and non-disabled students is illustrated by the lexical choice of ‘screening’ below, which can strengthens the references underpinned by a discourse of abnormality. The word have been utilised frequently when describing a process at the embryonic stage in the educative process, whereby students are expected to complete a questionnaire about their learning needs. However, the excerpt below does not correspond with this ideology, but rather attention is directed towards potential unsafety.

6.3.3 Discourse strand of mental health is different to disability

This discourse strand is focused on the constructs around disability and how mental ill health is placed outside of this discourse. I will present excerpts which not only suggest disability and mental ill health are different constructs, but how disability is long-term, while mental ill health is transient and may have implications on accessing reasonable adjustments.

The first student below discursively conflates the disability office and adjustments to mean dyslexia, a stereotypical predication demonstrated by many participants. When asked if the service was aimed at other people, he/she indicated surprise and expressed her unfamiliarity with this predication. This was reiterated by another student below, who asserts adjustments are exclusively for dyslexic students.

> "…you've got that unit [disability service]…is all for people who have a learning difficulty like dyslexia…" (Si3, page 9)

> "Erm, reasonable adjustments are for dyslexic people…" (Si20, page 6)

The predication that reasonable adjustments are solely for students considered dyslexic have been adopted by students within the study, suggesting the persuasive and hegemonic power of the current ideology. In the excerpt below, the word 'screening' has been used as a metaphorical devise to denote dyslexia. The lecturer intensified this notion by correcting self in the utterance, making the relationship between 'screening' and 'dyslexia' unequivocally connected.

> "…they would need to go through an assessment, I mean the dyslexia screening…" (Li19, page 5)

This suggests that other disabilities are excluded from the process, therefore reinforcing the stereotypical predication that people regarded as disabled within an educational environment are simply dyslexic. Therefore if the process excludes other disabilities including mental ill health, then it could be argued that the decision not to attain adjustments for some students has already been dictated by a discourse of identification. The dominance of dyslexic discourse reinforces and legitimises the exclusionary practices and ensures discriminatory barriers within education are maintained for some students considered disabled under UK legislation.

A similar excerpt is demonstrated below which serves to justify an absence of mental health adjustments, but is legitimised by using the topos of numbers, allowing the conjecture that student mental ill health is atypical. This utterance emphasises the legitimacy of adjustments for dyslexic students, while simultaneously making more conclusive the de-legitimisation of adjustments for students experiencing mental ill health.

> "They're more for dyslexia because they're the ones that are more likely to have come across." (Li6, page 8)

These excerpts suggest assumptions are made by educators as no participant has illustrated how this practice is documented in university procedures. This assertion is emphasised in the excerpt below, which suggests an interpretation and co-construction of procedure amongst educators which may or may not be sanctioned practice. In all of these recent excerpts, the absence of other significant explanations and reflections about why adjustments are predominantly attributed to dyslexia are not examined.

Additional legitimisations for the absence or paucity of mental health adjustments were commonly illustrated by the fallacy of common practice. This argumentation strategy which allows a variety of scenarios or justifications to be put forward in order to be excused from any wrongdoing due to widespread practice is illustrated below through a scenario.

> "If they had a broken leg and they were coming back into practice, we would have to make reasonable adjustments for them to be able to work. If they've got depression, you wouldn't, no-one would be expected to make reasonable adjustments." (Li4, page 5) "I don't know really, it's just always been like that…" (Li4, page 6)

Firstly, it is important to note, this lecturer's use of the words 'have to' demonstrates obligation, an utterance infrequent within the findings. The

lecturer's utilisation of this fallacy serves to excuse themselves from discriminatory practices due to tradition, but also mitigates any potential solutions, therefore maintaining the status quo. The utterance demonstrates a further interpretation and misunderstanding of the term 'disability' as documented in statue. The example of a 'broken leg' is unlikely to be considered as long term and therefore any adjustments made would not correspond to this legal duty.

However, while the majority of participants discursively characterised the assessment as signifying the identification of dyslexia, it was not the only construction. For instance, two lecturers referentially asserted the process as identifying learning needs of all constructions of disability.

> "My understanding is it's a general disability assessment of which they can identify people who need to go for a specific disability assessment which would then identify specific disabilities." (Li7, page 8)

> "…so my understanding is that they fill in the initial screening form which is very general…" (Li12, page 3)

Both lecturers position self in the discourse with the use of the words 'my understanding'. This insinuates a personal interpretation of the assessment process, allowing for any responsibility to be placed elsewhere if found to be incorrect. The first excerpt reinforces the predication that disabled people categorised into specific groups are the same and are allocated to such by others. The discourse is maintained as the social practice described refers to the student as 'they', a hasty generalisation which infers a whole-group rather than individuals. The utterances assume all students represented by the word 'they' are considered by others or identify self with a disability label. Furthermore, the process concentrates on the student's impairment allowing for professional and diagnostic discourses to prevail over a student's request or self-identified need. It can be argued that this

perpetuates a discourse which silences student voices and strengthen the power attributed to the professional.

A counter-discourse has been demonstrated by one lecturer who employs a topos of numbers to de-legitimise a discourse of difference, while simultaneously playing down the barriers faced by disabled students, both past and present. The utterance follows a discussion on the questionnaire previously discussed.

> "Everyone fits this category, we all could get this [reasonable adjustments]." (Li12, page 2)

It is important to note, the lecturer was unable to describe any anecdotal or knowledge about reasonable adjustments aimed at reducing barriers faced by students experiencing mental ill health. Therefore it can be argued that the excerpt demonstrates the fallacy of shifting the attention away from the issue of not executing reasonable adjustments. In addition the utterance suggests that adjustments are not required as people generally face barriers within education, therefore demonstrating how the status quo is accepted and maintained. This argumentation serves to place the needs of students with impairments in the background and as a result, conceal the presence of discriminatory practices.

Other examples given by mentors and students demonstrate an inaccurate interpretation of a reasonable adjustment. For instance the mentor below suggests the meaning of supernumerary during clinical practice corresponds to reasonable adjustments. Firstly, supernumerary is a status which is ascribed to all students with the intention of enabling students to be mentored by qualified colleagues and have time away from patient interaction to aid additional learning.

> "It may be that they are supernumerary, that's how I understand reasonable adjustments." (Mi22, page 8)

The student when asked about what reasonable adjustments could be put in place, suggested access to breaks, which is inconsistent with the legal definition of reasonable adjustments and unrelated to disability. The student's argumentation strategy is underpinned by a requirement to eat, passively mitigated by the use of the words 'may be something like that' and 'a chance'. This suggests that students and qualified practitioners don't get a chance to eat.

> "…so maybe something like that, that ensure that I got my breaks and erm that I got a chance to eat something." (Si20, page 8)

Both these excerpts demonstrate a misunderstanding around disability and reasonable adjustments. Both these participants during their interviews highlighted discriminatory practices towards mental ill health. Therefore, it can be argued that these excerpts demonstrate a misunderstanding of disability and reasonable adjustments, which allow discriminatory practices to be accepted and go unchallenged.

A further excerpt was presented which served to legitimise the discriminatory practice of withholding adjustments. A discourse around sameness was illustrated by one lecturer who asserted that the needs of students who are known to have a mental health condition do not have any aspects unique to that individual.

> "The same as everybody, absolutely the same as everybody else." (Li25, page 4)

The use of the word 'same' discursively groups all students together and is intensified by the use of the word 'absolutely'. It is believed that this lecturer deployed the word 'same' to denote the concept of equality. However it can be argued that this de-legitimises any specific practices which may enable the student's learning and practice needs to be met. The utilisation of the concept of equality mitigates any notion that the learning environment is designed and delivered in a way which creates barriers for students experiencing mental distress and therefore maintains the status quo.

Adding to the exclusion of mental ill health adjustments has been demonstrated by re/constructing mental ill health as transient. For instance the lexical choice ‘previously been’ illustrated below suggests past tense, therefore something that has previously happened. This suggests once the harmful effects of depression have subsided, the student no longer has depression and therefore not considered disabled.

> “LSP if there’s, if there’s not a learning need, if there’s a, I wouldn’t say, of how, who’s previously been depressed or something, I wouldn’t necessarily send you down, straight down to disability...” (Li15, page 8)

The excerpt also demonstrates how the word ‘disability’ is used as a metaphorical reference which allows the whole of the service within the university to be referred to. The excerpt suggests an ideological position that not only permits the lecturer to make a decision not to direct the student to disability services but also the role of decision maker in this context forms part of the lecturer’s role and therefore indicates power held by some people and not others.

This position has been demonstrated by the lecturer below via a suggestion of experience with students known to have a mental health condition. The lecturer clearly does not consider mental health as a disability. As this position is immediately verbalised after a discourse of uncertainty amongst self and colleagues, it can be argued that its use intends to mitigate a lack of knowledge and implementation of adjustments. The argumentation strategy utilised is the *false dilemma* fallacy, in that only two options are available, you either have a disability or you don’t. No other alternatives have been presented, which demonstrates its persuasive power to exclude student mental health from reasonable adjustments.

> “...we didn’t know where to start...we had to look at what there was in terms of disability but it was a mental health issue...” (Li6, page 10)

A lecturer was asked if a student who has a diagnosis of mental ill health would follow a similar procedure to students identified as dyslexic when obtaining reasonable adjustments. The following was stated:

> "I don't know because it's a different issue and you might say if it's a mental ill health problem perhaps it needs to be dealt with before the student is then on a clinical placement…" (Li19, page 8)

Firstly the lecturer employs a predication strategy which serves to emphasise her uncertainty by expressing 'I don't know' and 'you might say'. These lexical choices can serve to distance self and mitigate any responsibility. Secondly the lecturer's argumentation employs a predication which refers to mental ill health as transient by explicitly suggesting mental illness needs to be addressed prior to clinical placement. This suggests that mental ill health can always be eradicated and therefore does not fit with the legal definition of disability, legitimising the absence of reasonable adjustments. It is important to note, not just this participant but most participants within the study did not consider mental ill health as a disability.

A similar discourse has been presented by the student below who shared their experience of mental ill health throughout their nursing education. Contextually this refers to a student nurse in her final year, who repeatedly disclosed her mental health to lecturers and mentors. She is referring to her mental health being disabling.

> "When I was (pause) at times, (pause) yes [I was disabled], I wouldn't say now, but at times when I have had to take time out…" (Si2, page 5)

It can be argued that the student also considers her mental ill health as short term and as a result, needs to be excluded from education in order to eradicate or decrease the effects of mental illness. What is also significant is this student who consistently disclosed their mental health, had never been informed about reasonable adjustments. As the topic of reasonable

adjustments at one point became the focus of attention during the interview, the student reflected on the act of taking time out and suggested it was a reasonable adjustment. This suggests a discourse whereby the student had to reach a point of mental distress before this interpretation of adjustments was in place. This discourse which reinforces the conception that mental ill health equates to sickness rather than disability has specific implications for the student. This was made apparent by one lecturer whose argumentation, intended to justify excluding a student from accessing disability support is illustrated below.

> "…we tend not, or should I say I tend not to go down that road unless I see a student is really, really floundering and struggling." (Li25, page 13)

Firstly it suggests that a student who is mentally unwell could have access to reasonable adjustments. However, the lecturer did not speak of any examples whereby students known to have a mental health diagnosis also had adjustments in place. Secondly, waiting for a student to flounder could be argued as an unethical and an inhumane approach to support, intensified by the lexical choice of 'really, really' and employed to legitimise an absence of adjustments.

This ideological framework is incongruous to the legal position both stated in equality legislation and NMC documentation, whereby the approach to adjustments should be anticipatory and proactive. The excerpt below is an example of a statement in a significant NMC document within nursing and midwifery education that all participants will have access to. It states the criterion for being identified as disabled, considered a protective characteristic, documented in the Equality Act 2010. If a student meets this criterion, they will be legally entitled to a reasonable adjustment assessment, a discourse not directly disputed during this study.

> "…which has a substantial and long term adverse effect on their ability to carry out normal day-to-day activities." (NMC, 2010, page 7)

The statement utilises an evaluative strategy suggesting disability has to be long-term in order to be a protective characteristic. The document does not include a definition of what the legislation considers to be long term. However a discourse of difference as demonstrated above illustrates a position arguably incongruent to the NMC statement.

The findings have been able to identify additional constructs of mental ill health which contribute to this dominant ideology of dichotomising disability and mental ill health. At no point in the study was the suggestion that students with other disabilities are considered to be sick.

> "So if it's that bad then you go off sick, and if it's okay then you don't need a learning support profile..." (Li4, page 6)

The language use of 'sick' mediate an ideology which accepts mental ill health and sickness are interrelations. The lecturer employs a false dichotomy, a fallacious argumentation strategy used to legitimise the discriminatory practice of excluding students experiencing mental ill health from accessing reasonable adjustments. The only scenarios available to students is either to be off sick, or to manage your mental health and therefore not require reasonable adjustments, a predication irreconcilable with equality legislation.

Not only is the discourse entangled with a medical discourse (see 6.2), but has a causal power in that the construct can prevent access to reasonable adjustments which can negatively influence a student's education. This was verbalised by a student who during the interview reflected on the topic of reasonable adjustments. The student utilised an evaluation strategy of how her educational experience may have been different, suggesting her past and current experiences are difficult.

> "…you know I'm in my second year and it's a bit like why didn't I know before, and my life would have been a lot easier ..." (Si10, page 5)

The conception that mental health and disability are different may have been strengthened by the ambiguous interpretations demonstrated in the documentation examined. For instance, the excerpt below taken from an NMC document linguistically separates disabilities and health conditions but on the same page presents a paradoxical ideology by explicitly illustrating their synonymity within equality legislation.

> "The legislation protects people with a wide range of disabilities and health conditions from unlawful discrimination… It makes no particular distinction between health and disability issues…" (NMC, 2010b, page 7)

It can be argued that the first part of the statement reinforces a discourse of difference. This has the potential to strengthen the reader's perception that the procedure around reasonable adjustments does not subsume students experiencing mental ill health. Despite the document saying that equality law does not distinguish between 'health and disability issues', the lexical choice of 'and' reinforces this separation, similar to the statement below in the same document.

> "…to disclose disabilities and health conditions..." (NMC, 2010b, page 9)

Adding to the perception that disability and mental ill health are underpinned by a discourse of difference which strengthened the predication that adjustments are not for student experiencing mental ill health is the statement below. Despite the NMC making clear that the presence of a disability means a student can access adjustments, the exclusion of health conditions previously referred to does not form part of the statement.

> "If a student has a disability, the above criteria [Literacy and numeracy] can be met through the use of reasonable adjustments." (NMC, 2009, page 12)

The use of ‘health’ previously used can also reinforce a discourse of difference, especially as the NMC require students to be in good health. The excerpt below makes it clear that being in good health is paramount if students want to qualify and register as a nurse or midwife.

> “Good health and good character are fundamental to fitness to practice as a nurse or midwife.” (NMC, 2010b, page 5)

However, the term ‘good health’, in the context of a reference made to the good health form students are expected to complete at the inception of nursing and midwifery programmes has also been underpinned by a discourse of difference. If students consider themselves not being in good health, then they are expected to include this on the form.

> “…anything that isn’t good health and I would expect that if they had a mental illness that that would actually go on there.” (Li19, page 13)

The lecturer demonstrates a predicational strategy which serves to separate mental ill health and good health. A definite predication that good health excludes mental health, allows people experiencing mental ill health to be referentially defined as one group. The lecturer was asked to explain what good health was, but she was unable to answer, but did say “it’s a good question.” (Li19, page 10), suggesting uncertainty. This is strengthened by the NMC who uses the word ‘poor’ health not only differentiate between mental ill health and good health but reinforces the prejudicial generalisation that mental health is a negative construct.

> “If a nurse or midwife is in poor health it means they are affected by a physical or mental health condition that impairs their ability to practice without supervision.” (NMC, 2010, page 8)

The use of the word ‘means’ is a persuasive device, allowing the mitigation of other causal or contributing factors and at the same time reinforcing a medical model of disability. The dichotomy of ‘bad’ or ‘poor’ health indicates

being in ‘good’ health, a discourse dominant within NMC literature, as illustrated below. It is important to note, that the NMC in the same document indicate a counter-discourse which suggests disability and mental ill health does not always indicate an inability to be fit to practice. This statement, presented below suggests an acknowledgement by the NMC that a contemporary and discriminatory ideology exists within nursing and midwifery. If this was not the case, the statement would be superfluous. Furthermore, there is no evidence within the NMC documentation analysed within this study which indicates what good health means.

> “Good health is necessary…It does not mean the absence of disability or health condition.” (NMC, 2010, page 8)

The ambiguity and sometimes contradictory language may have contributed to educators and students understanding of mental ill health and its relationship with disability legislation and reasonable adjustments. However, it can also be argued that the content of disability training may also contribute. For example, during an interview, it became apparent that a lecturer’s role is extended to educate future mentors as well as students. Mentor pedagogy incorporated the topic of reasonable adjustments, but this also precluded a discourse strand of mental health, as illustrated below.

> “Yeah placement support agreement, so we do talk about that and show them what placement support agreement is, and talk about reasonable adjustments…In terms of mental health, I don’t do a specific session on mental ill health but some of that may come through in talking to the student mentors, but no it’s nothing...” (Li5, page 6)

Although mental health discourse was utilised, its role was to indicate its exclusion from the training material. The lecturer employs a perspectivisation strategy by linguistically positioning self in the discourse with the use of the word ‘I’. This is significantly relevant because it is a

discursive strategy predominately avoided by other participants when any negative self-presentation is possible. It is a plausible conjecture that no negative evaluation is either implicitly or explicitly associated with the exclusion of mental health adjustments during mentor training. The lecturer legitimises this exclusion by employing a discourse of difference, whereby the subject is only pertinent if initiated by the training participant. It can be argued that mental health discourses do not discursively correspond with reasonable adjustments, thereby justifying a faulty analogy whereby reasonable adjustments subscribe to disability discourses.

A counter-discourse has been presented by a lecturer who recognises that mental ill health and disability are synonymous. However, the lecturer's utterance not only reinforces negativity towards mental ill health, but its association with disability should be avoided.

> "…for us to then tell them that they have a label of a disability could be more harmful than good." (Li25, page, 12)

The excerpt above employs an argumentum ad consequentiam fallacy in that the word disability will lead to an undesirable consequence. The lecturer demonstrates how they have the power to decide who should adopt a disability identity. Furthermore, a discourse of difference is strengthened by referentially asserting the lecturers membership of one group linguistically referred to as 'us'. The 'other' is grouped together and illustrated with the word 'them' denoting students experiencing mental ill health. To separate the two, suggests the lecturer does not consider self to be a member of the 'other'.

6.3.4 Discourse strand of deviant behaviour.

A discourse of difference has also been endorsed through a discourse strand of deviant behaviour, predominantly through frequent referential strategies. For example the excerpt below demonstrates how medical categorisations when referring to mental ill health have been used alongside

predications usually illustrated by stereotypical traits and in a deprecatorily manner through discourses of behaviour. For instance while the mentor below discursively groups people labelled as having bipolar disorder, a stereotypical and prejudicial predication commonly attributed to this medical categorisation is verbalised. The words 'whizzing around' illustrated in the excerpt is a dysphemism, an expression which allows for an exaggeration which could be interpreted as negative. This dysphemism is employed to reinforce stigmatising characterisation that suggests unpredictability and irregularity, behaviours which may be deemed as inappropriate for nursing and midwifery practice.

> "Bipolar must make you very uneven, you're either very high functioning and whizzing around…" (Mi22, page 6)

The use of 'uneven' establishes a predication of unbalanced behaviour, which makes an underpinning discourse of unpredictability more persuasive. Finally, it can be argued that the lexical choices of 'must make you' also illustrate uncertainty, yet the mentor continues the sentence with conclusiveness around behaviour, thus making the verbalisation incongruous. The mentor also posits that this mental health condition is deterministic and therefore these behaviours associated with bipolar disorder are normative and predictable.

The mentor was not the only person who used discourses of behaviour underpinned by the stereotypical and persuasive predication of unpredictability. Language indicating this stereotypical trait does not necessarily require the use of similar words. It has been verbalised in different ways by different people, but have had the same or similar meaning. The lecturers below have used discriminatory language when describing behaviours associated with students presumed to have a mental illness.

> "…she just goes a bit bonkers sometimes" (Li25, page 4)

> "…they're having crazy thoughts or not thinking straight…" (Li19, page 4)

Both excerpts explicitly employ predications which are commonly attributed to mental ill health and are considered to have stigmatising implications. In the first excerpt, the word 'bonkers' is British slang to mean crazy or mad (dictionary.com, 2015) and therefore has the power to reinforces damaging stereotypes. This verbalisation is unclear what the behaviour being described is, other than different and transient. The anonymity of the student being discussed and the vagueness impedes on an understanding of what is meant and therefore reduces the ability to challenge the utterance. The second excerpt is similar in that the underpinning discourse around difference is legitimised by employing the *argumentum de hominem* fallacy. The individual or group of individuals' character is criticised in order to discredit their behaviour which allows for the claim to be more persuasive. As the predication is directly aimed at people experiencing mental ill health, it intensifies the suggestion that the absence of mental ill health presupposes thoughts are clear, yet it is accepted that unclear thoughts are experienced by everyone. Therefore it can be argued that this verbalisation indicates the expectation and standard of clarity is raised for people experiencing mental ill health. This argumentation strategy also redirects the focus onto the individual being discussed rather than the prejudicial attitudes held and demonstrated by the speaker. Furthermore the word 'crazy' is considered as a motif of mental ill health and is a commonly used referential metaphorical device outside the context of mental health. However in this instance, the derogatory word is used directly to attribute to mental ill health. Additional verbalisations of unpredictable behaviour stereotypically attributed to a person experiencing mental ill health are illustrated below.

> "…if they might act irrationally towards you all of a sudden and just snap at you." (Si20, page 4)

The verbalisation demonstrates its persuasive function by employing the trajectio in alium fallacy. Its role is to intensify the stereotypical predication

of unpredictability, while mitigating the participants own prejudice by reversing the role of victim into the perpetrator during a fictitious interaction with a person considered to have a mental illness. A similar example of mental ill health is presented below but additional stereotypical and prejudicial predications are revealed when describing behaviour.

> "…I suppose if somebody had like anger outbursts…" (Li25, page 8)

Both illustrative examples' functions are to present a persuasive argument with the intention of reproducing and justifying the insinuation of unpredictability and culpability. While the above excerpt could refer to anybody experiencing mental ill health, the excerpt below is specific to nursing students. Similarly to the above excerpts, the mentor below re/produces a discourse of unpredictability, but makes the claim more persuasive by employing an unreal and exaggerated scenario around reasonable adjustments which serves to intensify their argument. Firstly the mentor considers leaving the placement on any given day is a reasonable adjustment. Secondly, the use of 'I'm beside myself' not only presents a stereotypical trait, but also enables the vagueness and trivialisation of the experience of mental distress.

> "So they might have their own allocated mentor on a shift so they can go and say, do you know what I'm beside myself I can't do this today and leave." (Mi22, page 8)

Previously, this lecturer verbalised his/her understanding that Asperger's Syndrome was a mental health condition. Here the lecturer employs a discourse of behaviour when describing what is considered a mental health condition. The lecturer below illustrates some uncertainty as she links mental ill health and teaching experience of a student nurse presumed to have Asperger's Syndrome. It is important to note that this lecturer was asked if they were certain about this diagnosis. Their response was:

> “I’d put money on him having Asperger’s because of the way he, the characteristics, the way that he thought, the way that he communicated...” (Li18, page 3)

The metaphorical device ‘put money on him’ is an intensity marker which allows for the claim to be more persuasive and at the same time enables the speaker to be involved in the discourse. It can be argued that the use of these words trivialises and disrespects the persons presumed impairment, similar to the excerpt previous. The use of ambiguous behaviour traits linked to the categorisation also illustrates their uncertainty as they are not able to verbalise a substantial understanding. In this section, the findings demonstrate how all discourses of behaviour have focused on negative predications which all contribute to the stigmatising of mental ill health.

6.4 Discourse of Blame

The predicational discursive strategy extensive throughout all participant interviews and some documentation was discourses underpinned by blame. This dominant discourse was predominantly placed blame onto the student, but not exclusively. Blame discourses were commonly employed in order to mitigate any discourses indicating discriminatory practices among participants or the university as a whole. This discourse is broken down into four subsequent discourse strands of lack of resilience, disclosure, burden, and fear.

6.4.1 Discourse strand of lack of resilience

This discourse strand focuses on a stereotypical trait which considers people with a mental health label as lacking resilience, permitting the attention to be focused on the person considered mentally ill. In the first excerpt, the student was asked about his/her understanding of mental ill health. The student commences his/her understanding with a predication of deficiency informed by a discourse of resilience.

> "…someone's not that, that's not able to erm, something that affects a person … how they cope with stress, how they erm are able to deal with situations…" (Si20, page 3)

The suggestion that a person experiencing mental ill health lacks resilience, illustrates a taken for granted assertion that resilience is an expectant quality attributed to people in general. The lexical choice of 'something that affects a person' suggests an external factor rather than something that is a part of the person. However, the excerpt allows for any external factors considered stressful to be mitigated and students who experience difficulty are held responsible as a result of mental ill health. This is reiterated by the lecturer below who verbalises an external force, but presents a criticism underpinned by blame.

> "…they just need an extra stressor and they can't cope." (Li12, page 5)

The verbalisation not only denotes external factors have causal powers on resilience, but the lexical choice of 'extra' posits a quantity of stressors. The lexical choice of 'just' is a persuasive evaluative strategy which serves to intensify a discourse of fragility. In addition both the unavailable definition of 'extra stressors' and 'they' which serves to de-individualise the social actor, make the excerpt difficult to challenge and therefore illustrates a metaphorical devise which allows for an evaluative discourse of difference to prevail. The student-centric utterance deters any potential reflectivity on alternative factors, yet the word stressor' referentially points to a part external to the student, making the utterance contradictory. This was acknowledged by many participants, but is illustrated below by two examples from lecturers who established a relationship between the NHS environment and stressfulness.

> "…they're working in a highly stressed environment…" (Li4, page 8)

> "…it is a very stressful and demanding profession [nursing]" (Li8, page 18)

The utterances not only demonstrate the dominance of this representation of NHS environments, but also a suggestion which establishes an environment considered immutable. While these utterances may represent a fair description of working in the NHS, the acceptance of such, alongside discourses of resilience, allows for the predication that people considered to have a mental illness don't have resilience and may not be suited to the nursing or midwifery professions. These discriminatory discourses are intensified by the lecturer below who clearly links the requirement of resilience to work in the NHS.

> "…you do have to be resilient to be within the NHS…it's about having the ability to cope with things…" (Li25, page 11)

The lecturer therefore suggests that students, in order to qualify as a nurse or midwife, have to be resilient, a quality some participants have inferred as absent in students labelled as mentally ill. Furthermore no participant has discussed how the environment can change, thus accepting the need to acquire and sustain resilience in order to manage working in the NHS. As the discourse of resilience has only been ascribed to descriptions or evaluations in the context of student mental health, the presence of resilience is assumed to be a quality held by non-disabled students. However a counter-discourse, illustrated below was established by one student who suggested that some environmental factors have affected students in general.

> "…talking to people who've experienced bullying on placement…its really undermining your resilience…" (Si1, page 7)

Here the underpinning discourse of blame is placed with the NHS staff during student placement. The absence or reduction of resilience is

attributed to environmental factors rather than a feature of an individual. The verbalisation of 'its really undermining your resilience' expresses an ahistorical event rather than in the past tense, but may also be referring to confidence or self-esteem as it can be argued that resilience can not be undermined. Furthermore, the reference to 'people' not only allows for the student to position self outside of this discourse but also serves to intensify the predication of plurality. The anonymity of 'people' and the generality of the word 'bullying' strengthens the placement of blame onto the NHS environment, but makes it difficult to be a substantiated claim on its own. It is unclear if the anecdote includes self, but further on in the interview, the student recalls an experience which suggests an element of bullying, but this is not directly asserted. However the excerpt does indicate a discourse of expectant resilience. Prior to the excerpt below, the student claimed there were discourses indicating stigma around mental ill health within nursing and midwifery education. When asked to expand on the claim, she responded with the following:

> "Grow a pair, is quite a strong, anytime anyone is feeling a bit wobbly, just grow a pair…I've heard this said to me". (Si1, page 9)

The phrase 'grow a pair' is a stereotypical and sexist figure of speech which refers to a lack of masculinity. Its metaphoric intention here is to assert a negative evaluative qualification of people who may experience mental distress. This term implies that because a person is upset, they are weak, lack courage and need to return to an emotional state that is considered a quality of masculinity and conducive to nursing. Furthermore, it can be argued that the metaphorical device enables the speaker (in this case, a qualified nurse on a student's placement) to disengage in a conversation which provides support or a solution. This suggests the nurse's needs take priority over the student's needs, thus reinforcing a hierarchical relationship between students and educators.

A counter-discourse was expressed by a lecturer who initially redirects blame away from the student and towards the environment by asserting that the NHS and support given to students has potential consequences. It is important to note, the lecturer is not referring specifically to students with impairments, but students as a whole.

> "…it worries me sometimes that we allow students to continue in highly stressed situations without providing support for them because if something went wrong, we would be answerable." (Li4, page, 5)

This verbalisation reveals an awareness of an inappropriate availability of student support during clinical placement, contrary to previous excerpts. However, the appeal to consequences, underpinned by a discourse of blame redirects attention away from student's wellbeing and towards potential consequences to the lecturer or university. Solutions to this anticipatory outcome were not presented during the interview, therefore legitimising the continuation of an environment which many predicate as unsuitable. Not all participants evaluated the NHS environment as detrimental to student wellbeing and influence on resilience. For instance the lecturer below expresses a claim inconsistent with another lecturers' interpretation of the nursing environment.

> "…I'd be damn surprised, alright, if a student of mine that was unwell, was unwell because of nursing." (Li15, page 13)

The lecturer's claim de-legitimises a causal link between mental ill health and the nursing environment, but is strengthened by 'I'd be damn surprised' suggesting certainty. The excerpt also reinforces a social order, underpinned by language which denotes ownership and power through the lexical choice of 'a student of mine'. The excerpt allows the attention of ownership to be drawn towards the lecturer, suggesting that other students who are taught by colleagues may have differing outcomes.

6.4.2 Discourse strand of dishonesty

When lecturers have illustrated anecdotes around disclosure, an underlying discourse of blame towards the student has been applied. In the following examples, discursively linking blame and disclosure has resulted in a discourse strand of dishonesty. For example, the lecturer below illustrates how proactivity following a disclosure is rejected and replaced by latency. Contextually this is an anecdote of a conversation between the lecturer and a student.

> "…the student has said things that could be suggestive of suicidal tendencies, yet, actions of that person to me haven't done that at all, erm, and I think that person's learned to use those phrases to get attention." (Li15, page 7)

The utterance suggests a student is requesting help which may also be considered a disclosure. However the lecturer discursively transforms disclosure or request for help into dishonesty. This is achieved by the lecturer's indication that the genuineness of the student and mental ill health justifies suspicion while reinforcing the premise that professional's interpretation is more valid than the student's disclosure. The use of 'to get attention' not only reinforces a stereotypical and prejudicial predication and allows for an inactive response to distress but also suggests the verbalisation which indicates suicide is frivolous. The utterance does not clarify what 'actions of that person' which demonstrates suicidal suggestions, therefore making the claim difficult to challenge. At no point in the interview did the lecturer refer to reasonable adjustments for any student experiencing mental ill health, therefore it can be argued that this disclosure or request for help may not have triggered an assessment for adjustments.

The lecturer below makes an explicit reference to dishonesty. This is strengthened and made legitimate as a result of it being incongruous with regulatory standards.

> "…it's quite possible that students won't disclose, but what would concern me in that case would be the issue of dishonesty, because obviously to sign the student off at the end of their course as a registered health professional, honesty and openness are attributes which are essential" (Li19, page 3)

The lecturer uses language such as 'won't disclose' which insinuates a choice made by the student not to disclose. Here the student is accused of failing to disclose which demonstrates a victim-victimiser reversal (*trajecto in alium)*. Its persuasive function enables the blame to lie with the student while simultaneously minimising any other factor which may have contributed to a non-disclosure. It can be argued that this participant's understanding of disclosure is a requirement rather than a choice made by the student. It also demonstrates the perceived power held by lecturers to judge honesty. However, the lecturer is unaware of how the university communicates the expectation of disclosure to students and for what benefit, therefore indicating an inconsistent accordance with their own conclusion. Similar to the excerpt below, the lecturer links non-disclosure to a regulatory requirement, suggesting a possible unfit to practice evaluation. This permits the mitigation of a person exercising their right to privacy.

> "….we would consider it [non-disclosure] not to be compatible with good character… that would go down as professional misconduct…if they've had a diagnosis and not told us about it in Year 1, yes, they would be deemed to be dishonest." (Li7, page 14)

The relationship between non-disclosure and regulatory requirements is explicitly articulated by employing an argument by faulty analogy. Non-disclosure is discursively transformed into dishonesty. Dishonesty is a behaviour predicationally considered to lack good character, therefore

indicating misconduct. The articulation of 'professional misconduct' is underpinned by ethics which suggests unprofessionalism and wrongdoing. Therefore non-disclosure is comparable to professional misconduct which serves to justify the lexical choice of 'will go down', a metaphorical device pertaining investigation. Therefore the current interpretation of disclosure is arguably fundamental to a student's success.

While verbalisations around disclosure underpinned by a discourse strand of dishonesty have been prominent, other verbalisations have indicated a different element. The lecturer below established a link between LSP's and the disability service and was asked how students experiencing mental ill health know about the disability service.

> "They don't know it exists do they so they don't, you don't know what you don't know…should we tell them about it [disability office] then I think there are pro's and cons isn't there." (Li25, page 12)

Despite this counteracting with a discourse of dishonesty, no participant made a link between information sharing and non-disclosure. Here, the lecturer establishes the power of information, held by lecturers with regards to the disability office, but is withheld from students experiencing mental ill health. Not only does this suggest the power to control the flow of information resides with the educator, but also demonstrates how the procedure of attaining adjustments is manipulated according to the re/construction of those judged to be disabled and those who are not. Furthermore this ideological position serves to infantilised students considered to have a mental health condition by denying their maturity to make informed decisions and reinforces dependency.

An additional counter-discourse has been illustrated by some lecturers who not only predicate disclosure to choice, but also strengthen their argument by an appeal to consequences. The lecturer below, not only presents a

discourse inconsistent with colleagues, but indicates the prevalence of a mental health stigma in nursing and midwifery education, suggesting the decision to disclose can potentially be both a confusing and detrimental one.

> "…having a diagnosis can sometimes be discriminatory, so they don't need to necessarily disclose it." (Li18, page 8)

Finally, the example below is a narration of an unreal scenario about a student who has an LSP for mental ill health. The lecturer is referring to an electronic list of students who as a result of disclosure have reasonable adjustments written down on an LSP which also suggests a contradiction to the previous discourse of dishonesty.

> "…often I don't even look, I just leave it to them to disclose to me, because I think that's the way it should be." (Li6, page 20)

The lecturer de-legitimises a proactive approach by discursively establishing self as not responsible which serves to legitimatise the redirection of responsibility onto the student. This suggests that students have to disclose their mental ill health repeatedly due to the array of teaching staff a single student may come into contact with. The verbalisation serves to employ the argumentation strategy argumentum ad ignorantiam, allowing the lecturer to evade responsibility by appealing to ignorance. It allows the responsibility of groups, i.e. university educators, to be condensed to the responsibility of the individual, in this case the student. Furthermore the lecturer is able to demonstrate a power over resource by silencing the students' access needs. These excerpts not only demonstrate multiple interpretations of disclosure, but indicate that students are blamed for not disclosing, despite a lack of information about the benefits of such disclosure, or they are blamed for not repeatedly disclosing to all lecturers.

6.4.3 Discourse strand of burden

The findings demonstrate how student mental ill health is considered a burden to educators. The lecturer below reinforces a discourse of burden through the association of the word ‘trouble’ with students experiencing mental ill health.

> “The students in week one and you know full well you’re going to have trouble with them all the way through.” (Li4, page 9)

This demonstrates a ergo propter hoc fallacy, which allows the lecturer to consider the event of mental ill health which occurred prior to enrolment as the cause of events in the future indicated by the words ‘trouble with them all the way through’. This negative assumption is intensified by the suggestion of the lecturers previous experience through the lexical choices of ‘you know full well’ which serves to justify a judgement made after one week of interaction.

A discourse of burden has been explicitly utilised by the mentor below. The student experiencing mental ill health is predicated as having a detrimental effect on the educator’s workload as illustrated in the excerpt below.

> “…they’re not functioning very well it means that actually that burden passes onto you…the support you’re trying to give them, that’s an added workload to your day.” (Mi22, page 8)

The excerpt is contextually referring to students during their clinical placement. The discourse of burden is made explicit as the word ‘burden’ is directly utilised and directed towards the student who is referentially considered ‘not functioning’. The excerpt’s generality on what ‘not functioning’ is or what factors influence the students’s lack of functioning, disallows any challenge to the claim. The mitigation of any generative factors external of the student’s mental health serves to legitimise a

persuasive argument that allows the attention of blame to remain with the student.

Burden, underpinned by blame is also revealed by the lecturer below. The participant is talking about the Placement Support Agreement form which states a student's individual needs to ensure an inclusive environment prevails during placement.

> "...I think they've become a little bit meaningless, and certainly from a lecturer point of view, oh I've got this stuff, I've got this PSA to do and then sent it away, file it somewhere...it's every other student, oh here we go again, one of these." (Li12, page 4)

Firstly, the process claimed to be 'meaningless' was expressed with indignation and conveys a notion of unimportance. The commonality of PSA's is utilised to de-legitimise a student's access to an inclusive education. Furthermore the lexical choice of 'oh here we go again, one of these' illustrates a prejudicial ideology which mitigates and depersonalises the individual's experience, while intensifying the burden placed on the lecturer. The lexical choice 'PSA' and the absence of specifics allows for the utterance to refer to all disabilities, therefore presenting an impression that student's experiencing mental ill health form part of the narrative. However, it is important to note, no lecturer within the findings, made reference to PSA's specifically for mental health. It is a plausible conjecture that the anecdote of PSA's is a metaphorical device for a description of adjustments for dyslexia during placement.

Contributing to the argumentation of 'meaninglessness' may be influenced by the process of drawing up a placement support agreement. The lecturer is referring to information they were given at the start of their employment at the university under investigation.

> "The advice given by quite experienced colleagues was just to take what's from the LSP

> and cut and paste it wholesale into the practice support plan." (Li17, page 8)

The words 'cut and paste', a metaphorical devise suggesting copying, not only challenges the argumentation of increased workload, but suggests adjustments are not independent of context, allowing the justification of environmental duplicity. The utterance is underpinned by a discourse of burden as the practice of 'cut and pasting' demonstrates how the burden of creating two different assessments is eliminated. It can be argued that the needs of the student are secondary to the reduction of lecturers workload. Furthermore the utterance suggest the responsibility of adjustments during placement is placed with lecturers, therefore excluding the experiences and needs of the mentor and student.

Similar to the previous quote, a discourse of burden when referring to disabled students have been illustrated by other lecturers. This has been achieved by a predicational strategy in the context of planning lectures, a pivotal role within teaching. The excerpt below is an example of what a lecturer considers a reasonable adjustment for students experiencing mental ill health.

> "…it may things like ensuring that students have lecture notes before lectures which is very difficult because we don't operate a lecture based curriculum, so, it doesn't actually work that way." (Li19, page 5)

The excerpt refers to providing lecture notes prior to a lecture, with the intention of enabling a student preparation time. Promptly after the example is verbalised, the lecturer immediately denounces its appropriateness within nursing and midwifery education, argumentally justified by the word 'difficult'. The lecturer initially acknowledges the unaccessible practice, but expels the suggestion by making the teaching programme the justification for the absence of this specific reasonable adjustment. The lecturer demonstrates the nirvana fallacy, an argumentation strategy which allows for solutions like pre-lecturer notes, to be rejected because they are not

perfect. At the same time, the utterance enables the attention of discriminatory practices to be drawn away from the lecturer, while mitigating the barriers faced by students.

In the context of assessment, the lecturer below reiterates a discourse of burden when referring to students who receive extended deadlines. Rather than discursively characterising extensions as contributions to inclusivity, the trajectio in alium argumentation is employed, allowing for students to be blamed for causing the burden.

> "…things like giving students erm extended deadlines, or flexible deadlines for assessments, that causes issues… It comes in, you're in the middle of your teaching and now you've got this flaming assignment to mark." (Li5, page 9)

Concurrently, the construction of counter-claims suggesting inaccessible deadlines is what 'causes issues' or other factors are suppressed, prohibiting further discussion. Finally the verbalisation of burden is further intensified by the lexical choice of 'flaming', a persuasive referential strategy denoting irritation which allows for the minimalisation of the barriers faced by students, while intensifying the lecturer's predication of suffering. A discourse of burden has also been reinforced by an economic argument to justify the absence of reasonable adjustments.

> "…for example, a student needed one to one mentoring with every patient…clinical practice are going to go, ha, ha, ha, think again. You can't afford to buy a staff nurse to follow a student round like a shadow..." (Li7, page 11)

The suggestion that an adjustment can be unreasonable due to financial constraints is an evaluative strategy reinforced by a non-existent scenario. The verbalisation reinforces a discourse of burden by the use of other argumentation strategies. For instance, the lecturer demonstrates how a

dysphemism, a negative exaggeration, through the words ‘one to one mentoring with every patient’ allows for the argument to be strengthened. The assertion is intensified by the metaphorical device of ‘shadow’. The metaphorisation reinforces a stereotypical and prejudiced discourse, whereby students considered mentally ill are presupposed to be homogeneous, permitting a fallacious generalisation that all require additional input from mentors. Any predications or argumentation which illustrates additional educative input put in place by the student is dismissed, allowing for the evaluation of dependency to persist. Finally it can be argued that the lexical choice of ‘ha ha ha’ is an intensification strategy, intended to qualify the proposition of financial burden and unsuitability.

A discourse of burden is presented in both NMC and university documentation, which emphasises a legal obligation, indicating a right’s based interpretation of reasonable adjustments, an element of reasonable adjustments overlooked by all the majority of participants, allowing for a discourse of burden to be discursively linked with workload as opposed to a burden created by legality.

> “The act [Equality Act, 2010] also makes it clear that it is unlawful to not make a reasonable adjustment for a disabled person.” (NMC, 2010, page 7)

A counter-discourse to burden was also established. This was achieved by lecturers who also reinforced a discourse of burden, indicating inconsistency.

> “…she was brilliant…and then suddenly odd…doing that interview has just made all the emotional energy that I expend in supporting students, it’s just made it worthwhile.” (Li5, page 4)

The lecturer above established a counter-discourse to burden when a student considered 'brilliant' was the context. The excerpt illustrates how the lecturer's interpretation of support is hierarchical depending on how the lecturer constructs each individual student. This enables some students to be considered less burdensome than others, as illustrated with the lexical choice of 'worthwhile'. However the use of 'all the emotional energy that I expend in supporting students', still allows a discourse of burden to exist.

Similar to the previous excerpt, a positive self-presentation is established when describing support given to students. In the excerpts below a positive self-presentation is utilised by the application of two metaphorical devices.

> "…that you've got to go that little extra mile with it." (Li6, page 8)

> "…and they really bent over backwards…" (Mi22, page 11)

The words 'extra mile' and 'bent over backwards' positively draws the attention to the lecturer's and mentor's input, but considers their support as something extra to teaching rather than part of their role. This also allows for the mitigation of the existence of discriminatory pedagogy and mental ill health experiences which make adjustments necessary.

An additional way that a discourse of burden has been acknowledged was through observations by students during their placements. The first student talked about a reflection they had during a NHS ward placement.

> "for someone who swallows things [objects not supposed to be swallowed] and is then in a surgical unit and the doctor, when the doctor came to speak it was like ooooh it's a bit naughty the way you're doing this…why are you wasting all this time and money. "they had his X ray up in the nurses' station which is a public area, of all

> the stuff that he'd swallowed, like oh come and have a look at this…" (Si1, page 19)

Previous to this excerpt, the student was discussing stigma of mental health and how it is prevalent within nursing. As a source of legitimisation, the student recounts an anecdote of an event observed on a ward and at a nurse's station. The excerpt demonstrates how a person is constructed by the student as a victim of stigmatisation. As the same time, the other social actors represented in the verbalisation suggest how the patient is linguistically re/constructed as an entertaining passive object. Ascribing the quality of deviant through the lexical choice of 'naughty' also suggests the patient is discursively infantilised, therefore eradicating any notion of adulthood. Furthermore the student suggests how the person is wasting time and money, reinforcing a discourse of burden on the NHS.

The excerpt below also replicates a similar discourse. The student is recounting a statement made by a nurse during a placement. The student explained how this contributed to the student's argumentation around non-disclosure of his/her own mental ill health.

> "I can't be bothered with these people, you know, there's the all these people on this ward whose dying who want to live and then these people just who want to kill themselves, it's just ridiculous, why do we have to have to have these people." (Si2, page 15)

The anecdote here establishes a discourse which warrants negative ascriptions towards people who have attempted suicide while others are predicated as deserving of medical treatment. This prejudicial and discriminatory ideology is enhanced by ascribing their illness to the word 'ridiculous' which serves to trivialise and de-legitimise the experience of mental distress.

6.4.4 Discourse strand around fear

The final discourse strand underpinned by blame is a discourse around fear. Firstly the student below explicitly expresses an experiential emotion of fear of being perceived as unwell as a consequence of other people's stereotypical and prejudicial ideological assumptions.

> "…my fear was, how will other people perceive me if I am not 100 per cent happy-clappy as a mental health nurse all the time?" (Si3, page 5)

It can be argued that the student's fear and aim to present self as '100 per cent happy-clappy' presents a persuasive argument of non-disclosure. However the predication also serves to reinforce as well as acknowledge the prejudicial ideology simply by demonstrating a need to disassociate self with mental ill health.

The dominance of fear of negative perceptions of others has been linguistically constructed by many students, but the student below illustrates how fear is felt by qualified nurses. The following excerpt demonstrated through experiential narration intends to illustrate an argumentation strategy used by a mentor. Here the student suggests the mentor advised non-disclosure, justified by a fallacy of consequence, therefore reinforcing a discourse of fear of punitive action and perpetuating secrecy.

> "…one nurse that I got on well with and I told him a little about some of my life before, some of the stuff that happened and he turned round and said, never go into an interview and say that, erm and try not to tell anybody else because if you know, people know you've got mental health you might not get a job." (Si9, page 13)

A discourse of fear is not always linguistically associated with perception but explicitly implied. It could be argued that the implication of punitive action and its association with mental ill health helps sustain an ideological

predication that legitimises a fear. For instance as part of a university document regarding fitness to practice standards, it states:

> "...and that a health impairment/condition or criminal convictions obtained either prior to or during registration as a student may prevent them from registering with the relevant regulatory body." (U1, page 2)

The excerpt contextually refers to a document regarding admissions to nursing and midwifery education. The implied discourse of fear of punitive action is two-fold. Firstly the excerpt suggests that mental ill health can be a reason why a person may be prevented from enrolling as a student or registering as a nurse or midwife. As a result students with a mental health conditon may choose not to disclose in fear of exclusion from nursing and midwifery professions. Secondly, making reference to both health and criminality in the same sentence allows for them to be collectivised and considered a whole group. This demonstrates how structural power can reinforce an argumentation which justifies a fear of punitive action to be associated with mental ill health. No other performative factors or anti-discriminatory rhetoric suggesting a counter-discourse was identified around mental health which may influence a student's ability to meet fitness requirements. The insinuation of criminality has been verbalised by some lecturers, via a specific example of a convicted murderer.

> "Everyone's heard of Beverley Allitt for example, and I think high profile cases like that can then have a ripple effect on how others are perceived." (Li18, page 8)

The example, not only suggests this stereotype is present within society but also the causal power of the discourse reinforces fear of people with a mental health label, intensified by notoriety. Not only has this perspective been confined to an interview, but another lecturer reinforces this discourse by disseminating it with students.

> "…an example of Beverley Allitt I always give to my students…" (Li15, page 17)

The lecturer demonstrates their persuasive power by sharing this stereotypical negative predicational qualification with students. Promoting a specific ideology has the causal power to influence student's understanding of mental health amongst the nursing population and create or reinforce hostility towards students and patients who experience mental ill health. It also has the potential to increase students who experience mental ill health, levels of anxiety and feelings of vulnerability if they interpret the narration to insinuate discourses of unfit practice.

Participants through experiential anecdotes or interpretations of procedure were also underpinned by a discourse of fear around punitive action. The lecturer below illustrates how a disclosure of mental ill health forms part of the admissions procedure.

> "…but somebody with a diagnosis of mental ill health, first of all that would be explored at the point of acceptance onto the course" (Li19, page 2)

The excerpt suggests a stereotypical and prejudicial ideology which conflates mental health and incompatibility with nursing is active and that a disclosure of mental ill health has causal powers with regards to admissions. The excerpt is able to establish a plausible conjecture, that a discourse of punitivity is feasible rather than just a fear felt by others.

The lecturer below through anecdotal references describes the experiences expressed by students to the lecturer, suggesting a fear of punitive action is not only accepted but reinforced by inaction. The behaviour illustrated by the words 'horrible' and 'make it harder for you' suggests negativity experienced by the student.

> "...I do have students that come back and saying my mentor was horrible, erm I guess if you don't conform, if you don't fit with the norm, erm then

> there's an increased risk that the mentor isn't going to like you in inverted commas and perhaps make it harder for you" (Li18, page 9)

The prevalence of this practice is intensified by the use of the word 'students' indicating plurality and familiarity. What is absent is a discourse of change, suggesting an ideological stability accepted as the norm. So if mental ill health is not considered the norm, as illustrated by many participants, then the excerpt above demonstrates how mental ill health can result in a relationship encompassed by punitive action.

The only participant who demonstrated an element of power resistance to a fear of or actual punitive action was the student below. This anecdote demonstrates a challenge from a student about her mentor, but resulted in a discourse strand of burden (see 6.4.3 for more excerpts around burden).

> "When I challenged her about it, passed me on to another mentor…and the other mentor, erm, I suppose it was partly because I wasn't in a great state to start working with someone new…so I wasn't in a great state to build up a good working relationship with her, and she'd been dumped with the problem student…" (Si1, page 2)

There are a number of words within this quote which need to be explored further. The student signifies herself as an object through the use of being 'passed on'. Here she rationalises her situation and continues to suggest a victim role, but the blame placed with the mentor has subsided and redirected towards the student. This has been achieved by reversing her role as the victim, resulting in being the victimiser of the second mentor. The decision to change the mentor seems a viable decision if a positive relationship could not be re-established, but the social power held by educators allows the concern to be unresolved and the mentor to continue to demonstrate an illegitimate use of power.

She makes use of a referential strategy by describing her circumstance via the use of the word ‘state’. It is feasible, that her lexical choice suggests the relationship with the original mentor had influenced her wellbeing, whether that be physical or psychological, but this is only alluded to and is not the focus of the narration. However as a result of this experience, the student talked about how she would not challenge a mentor again as a result of the consequences experienced, therefore re-establishing a discourse of fear.

6.5 Conclusion

This chapter presents the findings from both the documentary analysis and participant interviews. The dominant discourses of medical, difference and blame were demonstrated within documents and by all participants within the study. The three dominant discourses have been presented separately but were not always utilised exclusive of each other. However, each dominant discourse while distinguishable, have been underpinned by a medical model of disability in that the student’s mental ill health has been at the centre, allowing the mitigation of social and institutional barriers to go unchallenged.

This has been most prominent when medical discourse was frequently utilised when participants referred to students who have or perceived to have a mental health condition. Medical discourse was reinforced by language underpinned by biology, psychiatry and illness. Participants not only illustrated a one-dimensional perspective of mental ill health, but its frequent use and unquestionability indicated the power of the discourse and its prominence within nursing and midwifery education.

Similarities between educators and students understanding of mental ill health and reasonable adjustments have been found, and reveal a complicated relationship between accepted psychiatric labels, stigma and argumentations which allowed students to be considered different and blameworthy. However, it can be argued that the most influence on students with a mental health label has been illustrated by educators as a result of the power they hold during the educative process.

Contrary to some participants' assertions, mental health stigma is widespread within nursing and midwifery education. Both educators and students have demonstrated the dominance of stereotypical and prejudicial discourses which contribute to the barriers faced by students with a mental health label. As a consequence, the legal obligations stated within equality legislation are being unmet. The next chapter will focus on the discourses considered to be dominant and how they influence nursing and midwifery students with a mental health label. The chapter will discuss how the arguments presented will relate to the wider literature.

Chapter 7: Discussion

7.1 Introduction

This chapter addresses the three research questions (see below) by examining the dominant discourses identified in the verbal and written data presented in the previous chapter. The discussion is divided into three sections, each corresponding to a research question. For each question, there will be a number of discourses explored and related to the wider literature.

1. What discourses influence students, lecturers, mentors and university and NMC policies when referring to student mental health?

2. How do students, lecturers and mentors conceptualise their roles in the student's placement journey with regards to reasonable adjustments and fitness to practice requirements?

3. To what extent do dominant discourses, as they currently exist, influence students diagnosed with a mental health condition?

The first question addresses the dominant discourses used when referring to student mental ill health. It was clear from the beginning of the analysis that medical discourses were going to take precedence over alternative discourses around mental ill health. This was not surprising as nursing and midwifery education and practice is underpinned by medicine. What was unexpected and will be discussed was the prominence of stereotypical discourses, most noticeably, discourses around dangerousness, abnormal and resilience.

The discussion will then focus on the second research question which was to explore the discourses around the perceived role of the educator in relation to reasonable adjustments and fitness to practice standards. Since 2002 universities and regulatory bodies have had a legal duty to provide reasonable adjustments within a learning environment. Reading through the

data it became clear that the infrequency of reasonable adjustments for students with a mental health label were influenced by discourses around the concept of and procedures in ensuring student access needs could be met. Discourses around identification procedures, practices of 'extra' support and discourses of blame directed towards the student appears to have played a role in excluding some students from receiving reasonable adjustments.

Finally, a discussion on how these dominant discourses influence a student's journey to registration will be presented. It will be argued that medical, stereotypical and blame discourses have contributed to the absence of reasonable adjustments for students with mental health labels. The discussion will highlight how the dominant discourses appear to influence decisions about disclosure and have the power to impact on a student's mental wellbeing. To aid this chapter, some illustrative quotes will be presented.

To determine consistency throughout, the discussion will be in keeping with a discourse-historical approach. Links will be made with historically situated discourses and how they influence the current constructions of students with a mental health label and contribute to the persuasive argumentations given for dominant ideology and practices.

7.2 Discourses around student mental ill health

7.2.1 Medical discourse

A key finding from this study is how the language used when referring to student mental ill health was predominantly influenced by medical discourse. This was most notably reinforced by utterances of biomedical causation, psychiatric categorisation and sickness. The discussion below will demonstrate how these discourses formed part of the constructions of mental ill health and how they enabled students to be distinguished from each other. Finally, the discussion will show how the power of the discourse allows the students mental health to be the source of the problem while

mitigating social and institutional factors which may reinforce mental health stigma.

7.2.1.1 Biomedical discourse

The findings from this study illustrate a dominant discourse which suggests mental ill health is understood by participants as biomedical. As presented in chapter six (see 6.2.1), this was demonstrated through language used by participants when sharing their understanding of mental ill health. Most participants made reference to biology as an immediate response to the question on what is mental ill health. The lexical choices most frequently used include 'disease' or 'chemical factors' like 'neurotransmitters'. This reflects Baker and Menken (2001) and Craddock et al. (2008) who strongly argue that mental health conditions are 'brain illnesses'. They assert that biomedical construction is considered the most comprehensive scientific basis for psychiatry. Language used in this study maintains a discourse originating from the nineteenth century psychiatry (Thomas, 2011) which permits the conjecture that mental ill health has a natural substance and appears when a malfunction of the body is present. The study is able to reflect Rogers and Pilgrim's (2003) assertion that a biomedical model is still dominant today.

It can be argued that the dominance of medical discourse could originate from psychiatry trying to prove the profession's scientific and medical validity, a position asserted by Thomas (2011). Duggan et al. (2002) suggests that its dominance is also illustrated in an increasing number of biomedical research studies. It is therefore unsurprising that recent government policies around mental health also endorse a biomedical discourse. The Department of Health (2011a) document 'No health without mental health' does acknowledge psychosocial influences on mental health, but its involvement is overshadowed by the need to promote and support medical research, despite previous challenges made by key practitioners including Rogers and Pilgrim (2010) and Laing (2010) that no biological cause has yet been proven.

There was little evidence to suggest that subjective influences formed part of participant's construction of mental ill health. For instance, mental health stigma and non-disclosure, both illustrated within written and verbal texts were not entangled with or formed part of biomedical discourse. It can be argued that the power and hegemony around the discourse enables medicine to largely go unquestioned even though social causes are widely researched and accepted contributors to mental ill health.

Solely reinforcing a biomedical discourse has the power to see mental ill health as a problem residing with the individual student. Directing attention towards biology as the source of the problem reinforces what Beresford et al. (2010) describes as a deficit model of mental ill health whereby the focus is on what is wrong with the individual. The entanglement of a deficit model of disability and biomedical discourses has not been exclusive to mental health. Mortimore (2013, p.42) conducted a case study project which explored policy documents, and staff and student experiences via focus groups, interviews and questionnaires in order to explore attitudes and practices for the inclusivity of dyslexia in higher education. She found discourses around dyslexia were underpinned by 'medical deficit definitions' reinforced by words such as 'symptom' which also places the problem with the student.

Contrary to reinforcing a deficit model which allows the problem to lie with the student, the discourse was also expressed by those participants' who identified with a mental health label. This was reflected in Beresford et al.'s (2010) study which examined mental health service users' attitudes and thoughts about mental ill health. Despite experiencing prejudice and discrimination from the medical profession, service users found a medical explanation of their mental ill health helpful. Justification for such a position was attributed to a biomedical explanation being able to redirect blame away from self, a position supported by other studies.

Lincoln et al.'s (2008) research conducted in Germany explored the biomedical model verses psychosocial causation explanations on attitudes among psychology and medical students. They found a biomedical model

had the power to reduce mental health stigma as it was considered a plausible strategy for challenging a discourse underpinned by personal responsibility. Outside of the educational setting, similar findings on the influence causal explanations of mental ill health have been reported. Angermeyer and Matschinger (2005) conducted a survey of two representative populations, also in Germany, regarding attitudes towards people with Schizophrenia. They found that people who endorsed a biomedical discourse reported a reduction in blame. Two years previous, Angermeyer and Matschinger (2003) found that presenting psychosocial causes resulted in more favourable attitudes towards people with a mental health label.

The findings of this study do not support these previous studies. Although most participants reinforced a biomedical discourse, there was no evidence to suggest it contributed to a reduction in blame. The findings appeared to suggest that a discourse of blame towards students with a mental health label was widely endorsed (see 6.4). Other than students, lecturers and mentors who shared personal experiences of mental ill health, most participants who reinforced a biomedical discourse, placed blame and personal responsibility on to the student with a mental health label.

Students, lecturers and mentors also expressed other forms of mental health stigma. For instance, talk which illustrated the desire to keep a distance between self and those with a mental health label was expressed. It is a plausible conjecture that a biomedical model of mental ill health may have attributed to this, as a connection between biomedical discourse and social distance has been demonstrated within the wider literature. Angermeyer and Matschinger (2005) reported an increase in social distance by those who adopted a biological model. Lauber et al. (2004) conducted an opinion based survey in Switzerland and found that the general public who endorsed a biomedical discourse with regards to schizophrenia were also more likely to keep their distance.

7.2.1.2 Psychiatric categorisation

Psychiatric categorisation, a discourse strand of medical discourse, reinforced by the word ‘diagnosis’ or mental health labels were found frequently within the findings. Participants spoke of the need for a ‘diagnosis’ in order to identify a person experiencing mental ill health, which appears to show the importance placed with medical discourse and the need to categorise people. Participants reinforced this social practice when utterances of psychiatric labels were made. The reliance on labelling was conveyed by terms such as ‘anxiety and depression’, ‘schizophrenia’ and ‘bipolar disorder’. The regularity of these terms suggests they are considered appropriate forms of knowledge. Labelling is arguably a form of power as it facilitates and maintains a system whereby certain social groups have legal ‘power to’ define, describe and categorise others. From a Foucauldian perspective, psychiatric labelling entails hegemony as the practice is widely accepted, making resistance and social change difficult (Foucault, 1991).

The findings appear to show that psychiatric hegemony may create a barrier for professionals outside of the mental health sector as most participants were unable to demonstrate a clear and comprehensive understanding of the mental health labels used. Schizophrenia was referred to as ‘having two personalities’, whereas bipolar disorder was considered to be present when ‘you are whizzing around’. This reflects the work of Durand-Zaleski et al. (2012) who conducted a national survey in France and found that despite 95 per cent of lay people (n=950) recognised mental health terms like schizophrenia and bipolar disorder, only just over half were able to provide an explanation of what schizophrenia was and less than half could explain bipolar disorder. It can be argued that the similarly between Durand-Zaleski’s study and this study is of concern as health professionals are in a position of power which enables them to support students who may present mental ill health, whereas the general public are not. However, educators’ lack of understanding is not exclusive to health professional educators and mental ill health. Chanock’s (2007) study

around dyslexia within higher education also found that understandings of disability labels are misunderstood by educators.

Psychiatric hegemony was evident in, and reinforced by the NMC and university written texts. These documents, in line with equality legislation, illustrated an insistence on medically recognised conditions by making mental health labels mandatory in order to ascertain student disability status and to access specific educational needs. Medical discourses are therefore not just prevalent within the medical sector, but distributed and reinforced through educational and legislative domains. To gain access to reasonable adjustments, a diagnosis needs to be proven and can only be given by a medical professional. Its in-disputability ensures a psychiatric label is essential. A difficulty may arise for a student who wishes to demonstrate some resistance towards a psychiatric label if they want to be in receipt of educational support specific to their needs. This reflects Thornicroft (2006) who argues that medical discourse does not pay attention to whether the individual agrees or disagrees with the diagnosis.

The findings appear to show that participants, together with the documentation that identifies student support needs, endorse discourses underpinned by psychiatric categorisation. These have the power to make a distinction between those who experience mental ill health and those who do not. Participants described groups of people with the same psychiatric label as ‘students with bipolar disorder’ or ‘schizophrenia’. Documents grouped people together by using ‘disabled people’ and ‘people with health conditions’. The social practice of psychiatric labelling within education not only is underpinned by a discourse of difference in that it permits division of people, but simultaneously reinforces groupness. Ben-Zeev et al. (2010) asserts that grouping mental health labels maintains stability and homogeneity. He suggests the social practice advocates an understanding that considers students with particular symptoms must have a particular label attached to them and that those with that label are undistinguishable from each other. It can be argued that prioritising the psychiatric label also maintains stability in educational practice as the exploration of how a more

inclusive approach to delivering a nursing and midwifery programme was ignored.

Accessing knowledge around mental ill health from the individual student is limited as findings of this study appear to show that a medical interpretation is all that is required. This was directly emphasised by one participant who was informed by the student that they were experiencing depression. The lecturer's immediate response was 'how do you know that? Where's that from? Is that recorded?'. This reflects Oliver and Barnes (2014) who argue that a diagnosis only provides a partial view of the students' needs. There is a danger that the insistence of a recorded mental health label is only an administrative tool. It can be argued that this permits the university to regulate access to certain interventions rather than consult the student on their immediate needs in order to continue their education. What's more, the lecturer's focus on a proven psychiatric label dehumanises the situation and fails to highlight the mental distress the student may be experiencing.

An acceptance of psychiatric categorisation may be of benefit to some students, but the findings suggest that references to psychiatric labels may contribute to stigmatisation. This was evident when certain psychiatric labels such as schizophrenia were linked to pejorative predications more than others. Schizophrenia was verbalised by many participants and was predominantly followed by damaging stereotypical predications, as opposed to depression and anxiety which were rarely linked to stigmatising discourses. The findings show that a hierarchy of psychiatric labels is present. This was demonstrated when schizophrenia was discursively linked to dangerous behaviour, but also was the only psychiatric label expressed by participants as a mental health condition not conducive to the nursing and midwifery professions. A discourse of dangerousness was used to legitimise the exclusion of people with this diagnosis from nursing and midwifery education. It can be argued that the requirement of a psychiatric label brings mental health stigma to the forefront, resulting in prejudicial attitudes which may be damaging to the individual student and their chosen career path.

The association of schizophrenia and an increase in mental health stigma has been widely reported. Specific to nursing, Linden and Kavanagh (2011) conducted a study to find out what the attitudes were of both qualified and student mental health nurses towards schizophrenia. They found attitudes which indicated that the 'schizophrenic' labelling should be avoided. This is not atypical, as findings from other studies have reported similar responses. Imhoff's (2016) online survey whose sample was predominantly university students were given a story to read about a patient who experienced particular symptoms. One story included the psychiatrist's diagnosis of schizophrenia, while the other did not. The study found that a diagnosis of schizophrenia decreased people's perception of trustworthiness and increased the stereotype of dangerousness. Sadler et al. (2012) conducted an online survey in the US and found the word 'schizophrenia' increased people's perception of hostility. Similarly, Angermeyer and Matshinger (2005) found that amongst one-third of the participants felt that people with a mental health label were a danger to young children. Previous research and this study supports Link et al. (1999) assertion that mental health stigma is much more related to psychiatric labels than any other factor, but the findings suggest there is a hierarchy of psychiatric labels with some being more damaging than others.

Other disabilities, predominantly dyslexia were verbalised within participant interviews, but were not underpinned by a discourse of dangerousness. The perception that there is a hierarchy of disability has been identified in another study which focused on student disabilities. Olney and Brockelman (2003) found that students felt that a hierarchy of acceptability of disability was present within the university setting. Learning disabilities was perceived to be the most accepted, whilst mental ill health was the least accepted. The study demonstrates that mental ill health in comparison to other disabilities is not exclusive to nursing and midwifery programmes, but experience by other students.

Other than from students who indicated their own mental health label, both verbal and written texts failed to highlight students' experience of mental ill health. Rogers and Pilgrim (2003) argues that discourses around

biomedical causation and psychiatric labels contribute to this as the whole person is viewed in light of medicalisation rather than their mental ill health simply being a part of the person. Similarly Murphy (2011) found that students did not want to be labelled without other aspects of themselves being taken into account. Previous literature (Olney and Brockelman, 2003; Bos et al., 2009) and this study show that students are presented with a dilemma when thinking about disclosing a mental health label in order to receive reasonable adjustments as the consequences may outweigh the benefits.

7.2.1.3 Is mental ill health a disability?

The findings of this study have also highlighted how an illness model of mental health may reinforce a dichotomy between disability and mental ill health which appears to have contributed to the absence of reasonable adjustments. Students who 'go off sick' infers a health condition which has 'a substantial effect', a criterion associated with the legislative definition of disability, as presented in NMC guidance (NMC, 2010b). However, participants' understanding of mental health being discursively linked to sickness which can be treated by medicine reveals how mental ill health is perceived as temporary. This ideological position appears not to be conducive to the legal definition of disability which states a person's disability should be 'long-term'. As a consequence, an illness model arguably gives the impression that mental ill health is incompatible with this definition of disability. Distancing mental ill health from the concept of disability is reinforced in NMC documentation as the words 'disability' and 'health conditions' are presented together, indicating a distinction between the two concepts. When reasonable adjustments form part of the narrative, 'health conditions' are excluded from the text which appears to give the impression that adjustments are only for people considered 'disabled'. It is argued that this presentation of language reinforces the legitimisation of precluding students with a mental health label from accessing reasonable adjustments.

Mental ill health can be long-term and have a substantial effect, even when it fluctuates and the student experiences mental wellness (HMSO, 2010). This allows students with a mental health label to be identified as having a disability. However the findings suggest that it is unclear whether mental health is considered a disability, which makes the process of receiving reasonable adjustments much more complex. It is not only educators and the surrounding documentation which present this dichotomy between disability and mental ill health, but students who identify with a mental health label also differentiate between the two concepts and do not identify with a disability label.

Only one student endorsed a disability identity, but only when she considered herself to be unwell and needed to take time out from her studies. Similar to educators, the student perceives mental ill health to have a temporal status. Previous research has reported similar findings whereby students and service users of mental health services did not identify with the word 'disability'. Riddell et al. (2004) found that some students preferred an illness model rather than disability terminology due to mental ill health fluctuation. Previous literature also indicates that students with a variety of disability labels and not just students experiencing mental ill health are hesitant to adopt a disability identity. Riddell and Weedon (2014) found students were reluctant to consider themselves disabled despite knowing a disclosure could result in receiving reasonable adjustments. Fuller et al. (2009) reported students only considered themselves disabled when they entered university, partly as a result of enabling them to have their needs met. Olney and Brockelman (2003) found that students considered their disability status as context-dependent and situational. Students reported adopting a disability label to acquire adjustments and/or support, but may not personally identify with that label.

A disability identity is therefore shaped and constructed by social practices and not by the individual which suggests that the university transforms a student into a disabled person rather than is a disabled person prior to enrolment. Whilst disability can be experienced differently throughout a person's life, the literature suggests a resistance to adopting the term

‘disability’ is more connected to identity rather than mental ill health being perceived as having a temporary status. As a consequence, the stigma around the concept of disability remains stable and unchallenged.

7.2. 2 Stereotypical discourses

Continuing with the first research question, the findings of this study indicate that the majority of participants reinforced stereotypical predications when references about students with a mental health label formed part of the discussion. Stereotypes are knowledge structures which express certain beliefs about certain social groups or individuals of those groups (Corrigan and Kosyluk, 2014). The stereotypical belief is widely expressed and considered common knowledge among a particular culture. Within this study the most dominant discourses were around dangerousness and resilience.

7.2.2.1 Dangerous discourses

The most dominant predication employed by participants within this study was underpinned by a discourse of dangerousness. This was demonstrated when participants recounted negative descriptions of both pre and post registered nurses who have caused harm to patients in their care. It can be argued that this in itself is not discriminatory, but none of the narratives were referring to students who they knew or had come across in the past. Accounts were either in relation to cases reported in the media such as Beverley Allitt or hypothetical scenarios based on stereotypical assertions. It is a plausible conjecture that students with a mental health label are a cause for concern. However, only one anecdote of practice delivered by a student which resulted in devastating consequences was established in the study and their mental health did not form part of the narrative.

In order to successfully complete a nursing or midwifery programme, students are required to demonstrate their ability to work independently and ensure patient safety (NMC, 2008b). The latter competence is understandably one of the most important elements of a nurse’s or

midwife's practice and anything less would be unacceptable. Therefore the suggestion that a student is or is likely to be dangerous becomes a major concern for educators and the NMC.

The widely reported portrayal of people with a mental health label as dangerous illustrated in chapters two (see 2.6) and three (see 3.4) corresponds to the number of participants who reinforced this stereotype. The disproportionate discursive link between student mental ill health and unsafe patient care can be argued as discriminatory as no other account of unsafe practice by a student with a mental health label surfaced. It is plausible that a biological explanation previously discussed may have played a contributory role in reinforcing a discourse of dangerousness as participants who endorsed biological causation also predicated dangerousness. This reflects a study conducted by Walker and Read (2002) who explored the influence of medical and psychological discourses on mental ill health and the stereotype of dangerousness. They found that the medical discourse increased attitudes around the perception of dangerousness.

This discourse may have been fuelled by high profile cases of medical professionals who have committed horrific crimes against people in their care. As previously mentioned, the findings suggest the most notorious case was that of Beverley Allitt, who was convicted of four murders, nine attempted murders and nine accounts of grievous bodily harm (Davies, 1993). No other high profile case was mentioned in this study. This case was referred to by nursing lecturers when student mental health was being discussed. One of those participants suggested nurses like Beverley Allitt are common which serves to legitimise the argument around conflating dangerousness and mental ill health. Despite conflicting views and uncertainty about her mental health status and the case being referred to as a 'once in a millennium event' (Appleyard, 1994, p.287), the findings suggest it is easy to assert a persuasive and stigmatising argumentation with no evidence. This was also demonstrated at the time when the Clothier report (1994) recommended that people should be free of mental ill health intervention for two years before they could be considered safe to practice.

It was not until 2002 that this requirement was withdrawn from policy (Department of Health, 2002) as it was considered discriminatory.

The findings of this study also appear to show how the NMC may reinforce a discourse of dangerousness. Whilst the NMC recognises the benefit of widening participation in order to diversify the nursing and midwifery workforce (NMC, 2008b), there is an emphasis on balancing disability with patient safety. The argumentation, commonly written in the same sentence or at the very least, in the same paragraph indicates a concern around disabled students, including those with mental health labels. This discourse potentially reinforces the stereotypical predication that risk is more probable with students with a mental health label and other disabilities as patient safety is not discursively associated with any other group of students or qualified staff throughout NMC documentation. Emphasising disability or health conditions presents a conflict between promoting diversity and patient safety; an argument which Rogers and Pilgrim (2003) suggests reinforces and reproduces stigmatising discourses while negating equality obligations. If concerns arise about a person's fitness, it can be argued that this is a competence or conduct issue, regardless of whether a student's health is a contributing factor or not.

The findings are not surprising given the array of literature which presents a perception that people with a mental health label are dangerous. The Disability Rights Commission's (2007) formal investigation into the impact of fitness requirements on disabled people in teaching, nursing and social work professions found similar stereotypes. People's mental health conditions were perceived to be a major factor in being a risk to patients in their care and therefore would find it difficult to meet regulatory standards. Similar to this study, although this perception was frequently reported, participants were unable to give examples of how disabled people were a risk to patient care if standards for competence and conduct were applied. Similarly, Tee et al. (2010) found that disability service staff had heard mentors express concern about patient safety being compromised by disabled students.

The extent to which the discourse is established and powerful was represented by some students who identify with a mental health label. Students talked about how they made a conscious effort to give the impression that they were not dangerous. This also reflects the DRC's (2007) investigation as student and qualified nurses and midwives reported concerns about disclosing mental ill health due to a fear of discrimination around patient safety.

Stanley et al. (2007b) asserts that the NMC's role has become more prominent in recent years as a result of high profile cases which could be argued as a contributory factor. Despite numerous investigations resulting in nurses and midwives being struck off the register for unsafe practice, no evidence suggests that the majority of these relate to mental ill health. On the contrary, it is widely reported that mental ill health does not necessarily result in dangerous behaviour. The University of Manchester's (2014) national inquiry into suicide and homicide by people with a mental health condition reports that the majority of homicides were committed by people without mental health conditions.

It can be argued that the media's portrayal of mental ill health has influenced the reproduction of the discourse strand of dangerousness as some participants indicated their mental health literacy came from media sources. One participant when asked where their knowledge of mental health came from, responded with a UK popular television programme. The media as the main source of information for the majority of people has been found in previous research. Mortimore (2013) found that educators commonly source disability literature from the media. Durand-Zalaski et al.'s (2012), national survey of attitudes and knowledge towards schizophrenia, bipolar disorders and autism found that most participants considered the media as the main source of mental health information and over half perceived people with some mental health labels were likely to demonstrate dangerous behaviour. It is a cause for concern as Beresford et al. (2010) reported people with mental health labels found that the media demonstrated a lack of understanding. This corresponds with Nairn's (2007) review of 21 research studies which found the media's depiction of

mental ill health are based on lay understandings and portray people as different to others.

It is plausible that the media has a dramatic effect on how people with mental health labels are perceived, but the conception of dangerousness has a long history. Rosen (1968 cited in Pilgrim, 2009) assert its origin was during antiquity. Long and Midgley (1992) suggest the conflation between mental ill health and criminal behaviour originated from the nineteenth century, when psychiatry in its infancy was combined with the legal system. More recently, Quinsey et al. (1998) suggests that dangerous discourses became more significant during the 1960s as mental health practice was predominately focused on managing people within institutions. Blumenthal and Lavender (2001) assert that the predication of dangerousness became a societal concern as people were supported within the community. Roger and Pilgrim (2003) criticised mental health policies for being excessively bias towards the perception of dangerousness and lacking in civil liberties. It is unsurprising that this discourse was one of the most dominant within the study considering the vast amount of information which supports the belief.

Students who are constantly learning are likely to make many mistakes around patient safety throughout their nursing and midwifery programme, which is why the NMC require all students to receive direct supervision. Dale and Aiken (2007) who recognise the possibility that students at some point will pose a risk to patients in their care argue that this could be attributed to the level of support given to that student regardless of their disability. This position indicates a social model view of disability in that it is not the individual student who is the cause of unsafe practice, but the environment in which they work in. Throughout this study, no links were made between a lack of support and adjustments and the potential to pose a risk. The perception by most participants was that the problem resided with the students' mental health if unsafe practice was carried out.

7.2.2.2 Discourse of abnormal

The perception that students with a mental health label are different from others has also been illustrated by dichotomising students when normative comparisons were endorsed. Students without a mental health label were linguistically referred to as ‘normal’, which is a persuasive device to assert that students with a mental health label were not ‘normal’. One participant directly used the word ‘abnormal’ as a referential strategy to identify a person experiencing mental ill health. This was also found in Lauber et al. (2006) whose survey to find out if mental health professionals stigmatise their patients found the word ‘abnormal’ was endorsed. Hughes (2007) suggests that it is underpinned by the assertion that mental ill health is ontologically deviant. Despite the prevalence of this dominant discourse no definition of ‘normal’ was presented within this study or the wider literature.

Its use demonstrates the workings of power in that it legitimises dissimilarity and strengthens the assumed difference between those with and without a mental health label through evaluative assertions. Foucault (1988) suggests the conception of normalcy was during the Classical period in the context of economics and morality, which justified the development of the Great Confinement. He argued that the term ‘normal’ is valued-laden and a social judgement (Foucault, 1991) which has enabled participants to separate people and their behaviour from what is considered the majority.

It can be argued that it reinforces students to be stigmatised to ‘us and them’, by positioning the student with a mental health label as ‘other’. This is supported by Leshota (2013) with regards to disability generally. He argues that this social practice re/constructs a hierarchy of ‘us’ and ‘them’, with ‘us’ stipulating the norms of mental wellbeing and mental ill health, while ‘them’ maintains passivity and acceptance.

7.2.2.3 Discourse of resilience

The term ‘resilience’ or ‘to cope’ has been used by most participants to illustrate a quality essential for nursing and midwifery practice which may be absent in the student with a mental health label. The discourse, used on many occasions reinforces the focus on what is missing in people with mental ill health in comparison to others, a belief underpinned by a medical discourse. The word ‘resilience’ is defined as having the capacity to recover from difficult situations quickly and corresponds to toughness (OxfordDictionary.com, 2016).

The findings appear to show that when a student is seen as not coping or is experiencing stress, he or she will be assumed to have a mental health label yet it can be argued that we deal with numerous adversities every day which can have varying effects. Similarly, Becker et al. (2012) found that one third of faculty members thought the experience of stress meant the presence of mental ill health. The Mental Health Foundation (2001) reported the perceived causes of mental ill health were thought to reside in the behaviours of the students’ inability to cope. This is not exclusive to mental health as Miller (2002) found that college students with learning disabilities were considered resilient if they demonstrated coping mechanisms when dealing with attitudinal barriers. Despite participants’ assertion that nursing and midwifery education and practice is stressful, an evaluation of the NHS reflected in previous reports (RCN, 2013; Francis, 2013) and the presence of mental health stigma within this study, it is still the individual student who is repeatedly identified as the problem.

The frequency in which participants reported the need to be resilient suggests success is dependent on the ability to overcome adversity in order to continue to work in the NHS environment, which makes resilience an unofficial but expected competence measure. This reflects McDonald et al. (2012) who argues that resilience should be a fundamental part of training for student nurses and midwives. This is not disputed, but ignoring the needs of students experiencing mental ill health may affect a student’s

resilience which Vickerman and Blundell (2010) suggest may force students to conform to and fit into the existing culture. For some students this has included bullying, which has contributed to mental distress. This is of concern as one lecturer accepted that bullying of students was part of the NHS culture and is experienced by many students. It can be argued that an acceptance of this discourse and the current NHS culture means that students require superior resilience ability and that the NHS culture is normative and stable.

7.3 Discourses around the roles regarding reasonable adjustments

This section of the discussion corresponds to the second research question which examines how both written and verbal texts conceptualise educators' roles with regards to reasonable adjustments and fitness to practice requirements. The findings of this study indicate an array of interpretations around the social practice of reasonable adjustments from how students are identified as having learning needs which may result in adjustments, to their implementation during the nursing and midwifery programmes.

7.3.1 Identifying students for reasonable adjustments

Both NMC literature and participants acknowledge that accessing reasonable adjustments are contingent on disclosure, a process referred to as 'declaring' a disability. It can be argued that the word 'declare' implies the student has a secret which needs to be communicated to the university and placement partners. It can be argued that this only applies to students with hidden disabilities as students with visible disabilities are declared by their physicality. Declaring a disability has been legitimised by ensuring that the student does not compromise health and safety and, if eligible can receive reasonable adjustments.

It can be argued that the process subscribes to students being stigmatised to 'us and them', as declaring a disability is underpinned by a discourse of difference. This is amplified for students with a mental health label as the findings indicate that 'declaring' mental ill health does not necessarily result

in the receipt of reasonable adjustments. The aim of the declaration is therefore to identify if the student is a health and safety risk which has the power to reinforce a stereotypical predication of dangerousness. As the findings illustrate, students with other disabilities receive reasonable adjustments, therefore the outcome of a disclosure of mental ill health is dependent on the educators' construction of disability as opposed to the legal obligations of the university.

Participants also talked about a questionnaire which all students are expected to complete at the start of their education. The intention is to identify students with a disability. Participants linguistically referred to this process as 'screening' or 'screening out'. The process serves to enable students who may benefit from reasonable adjustments to be identified and assessed. It can be argued that the language use contributes to the exercise of power in a subtle way as it reinforces a relational social practice which legitimises the separation of students from each other. This process reflects the work of Oliver (1990) whose critique of the medical model of disability reinforces the practice of identifying those who are perceived as different from the social norm.

'Screening' and 'declaring' not only allows the focus to be on the individual student, but it ignores the issues around disclosure. Other than students not being perceived as 'disabled' by themselves or educators, interview data demonstrates a reluctance to disclose mental ill health due to perceived or actual experiences of mental health stigma. This reflects an array of studies including Martin (2010) who conducted an online survey to students enrolled in an Australian university found that the majority of students with a mental health label did not disclose due to a fear of discrimination including the exclusion from higher education. Olney and Brockelman (2003) found that students still reported negative responses to mental health disclosure.

The decision to disclose is ultimately a right exercised by the student, but the findings of this study illustrates how non-disclosure is considered synonymous to dishonesty. A discourse of dishonesty was frequently verbalised when it became apparent in the interview that students with a

mental health label were not receiving reasonable adjustments. Defending the absence of adjustments, educators utilised an argumentation strategy which enabled the blame to be redirected onto the student's non-disclosure. As a consequence, students were evaluated as having a 'bad character' by one lecturer, which supports Goffman's (1963) claim that having a hidden stigma allows people to make discreditable judgements based on stereotypical ideology. This reflects Olney and Brockelman (2003) who found students had experienced negative messages from educators which have alluded to dishonesty.

The expectation of being perceived by educators as dishonest was not verbalised by students within this study, but previous research suggests that a discourse of dishonesty can be internalised. Martin (2010) found that students reported feeling like a disclosure would be considered a dishonest pursuit of receiving additional support and therefore unjustified. Both these studies show that students are aware of the discreditable stigma which could exacerbate mental distress.

Being discovered to have a mental health label may have other devastating implications as the term 'bad character' demonstrated in the interviews may result in being assessed as unfit to practice. It is unsurprisingly that 'bad character' and 'dishonest' have been discursively linked as both terms appear in the 'Good health and good character' NMC guidance (NMC, 2010a). It appears that this link is dependent on the educator's subjective interpretation of the NMC guidance as no other participant made a link even though dishonesty was illustrated by other participants. It can be argued that this may be attributed to the content of such guidance documents as other research has found confusion among educators. Both Wray et al. (2007) and Griffiths et al. (2010) found that educators considered the policy and guidance unclear and participants in Stanley et al. (2007a) research attributed confusion to vague and non-specific wording. For those participants who did not make a link between NMC guidance and dishonesty, it can be argued that the discourse suggests that the 'screening' process is about complying with the university's agenda as

opposed to the student's right to make an informed decision about disclosure.

7.3.2 The concept of reasonable adjustments

The findings indicate that the concept of reasonable adjustments was mediated by the speaker's construction of mental ill health. Examples of reasonable adjustments demonstrated how student mental ill health and sickness were interrelated, allowing the student to be re/constructed into a sick role. This was endorsed by educators' interpretation that going 'off sick' was an example of a reasonable adjustment for mental ill health. This reflects Double (2006) who asserts that people's immediate and prominent response to a mental health disclosure is to assume the person is sick. The findings appear to show that students were obliged to see a doctor and accept medical recommendations, which reinforces an ideology that mental ill health requires rehabilitation. Not only does this allow a dichotomy of health and ill-health, but places students with a mental health label in the latter category. This suggests that students are unable to return to education, until they can demonstrate wellness and reinforces the construction that mental ill health is not a disability.

It can be argued that this validates medical paternalism and resembles Foucault's (1991) 'disciplinary regime' whereby the student experiencing mental ill health has to go through a process of rehabilitation before they can be allowed to return. This reflects the work of Lawson (2008) who suggests a rehabilitative approach to adjustments reinforce the premise that the individual needs to change in order to fit into the world around them. It is argued that this conceptualisation of reasonable adjustments has the power to ensure solutions underpinned by medical discourse take priority. The educators' ability to make that request is dependent on the hierarchical relationship with the student, is context-dependent and relies on a paternal impulse to intervene. As no other alternatives were given, it can be argued that the power resides with medical and educational professions' constructions which take precedence over the students' construction of self. However, as students spoke of taking 'time out' and a

resistance to such interventions were absent, it can be argued the construction of mental ill health and a lack of information has led to students as passive beneficiaries of medical power and consensus among the education population.

Examples of reasonable adjustments for mental ill health which reinforce a medical approach have been illustrated in other studies. Tee et al. (2010) conducted an evaluation case study to explore the support work of student practice learning advisors (SPLAs) for disabled students on nursing programmes. The reasonable adjustments provided in the study included encouraging students to use counselling services. Cook et al. (2012) whose study explored the effectiveness of medical students carrying a Student Support Card which intended to enable students to take control over accessing reasonable adjustments. The study was able to present an array of reasonable adjustments which may be of benefit to students. The adjustments highlighted for students experiencing depression or other 'psychological problems' included absence for regular therapy appointments and to understand the need for sudden unexplained absences. These examples may benefit some students, but there is a concern that they have the power to give precedence to an illness model of mental health, while neglecting the array of evidence within this study and previous research of the importance of tackling mental health stigma and discrimination.

Despite an absence of reasonable adjustments for students with a mental health label, the concept was recognised by all participants, but they were considered synonymous with students known to have dyslexia. Unlike the rehabilitative approach to mental ill health, adjustments for dyslexia appear to be more compensatory. This ideological approach reinforces the predication that the student is lacking and in need of additional support, allowing the focus to remain with the students disability. This was demonstrated by the word 'extra', a referential strategy to denote a reasonable adjustment, commonly used in other studies. Cook et al. (2012) and Howlin et al. (2014b) both gave examples of students receiving extra time as part of their reasonable adjustments package. Mortimore (2013)

found lecturers' endorsement of extra time reflected their low expectation of the student's ability.

As a consequence, the language use of 'extra' may have re/constructed the student's reasonable adjustments as an injustice to non-disabled peers who have reported feeling at a disadvantage. This appears to show that some participants do not recognise disabling barriers within higher education, a finding reflected in other studies. Riddell et al. (2007) reported concerns raised by lecturers who considered reasonable adjustments gave an unfair advantage to disabled students. Riddell and Weedon's (2006) case study of dyslexic students explored the role and provision of reasonable adjustments within higher education. They found that participants' construction of reasonable adjustments verbalised as 'special treatment' and 'allowances'. Martin (2010) found that some students internalised the judgment of advantage by reporting they did not want to be perceived by others as 'wanting privileges'. Similarly, Brown et al. (2006) conducted an Australian study which explored the experiences of health profession students practice placements. They found that students did not want to be receive 'special treatment'. In contrast, Mortimore (2013) found non-disabled students in support of adjustments for their disabled peers.

A counter-discourse was identified in Hargreaves et al. (2013) as students felt their disability did not result in 'extra' time or support but would mean they had to put in additional time to ensure they met the required fitness standards. Similarly, Goode (2007), a case study of a UK university explored the experiences of disabled students, including those who identified with a mental health label. Students reported additional time was spent trying to get agreed reasonable adjustments to be implemented by educators which provides a contradictory argument, in that students are not advantaged by adjustments, but disadvantaged by their inconsistent implementation.

Giving something extra to students has also been verbalised by educators when describing their supporting role for disabled students as 'going that

extra mile', 'bending over backwards' or 'making allowances'. These utterances infer that educators considered their supporting role and implementing adjustments as an additional task as opposed to part of their role which is arguably underpinned by a discourse of burden, also dominant within the this study.

7.3.3 Discourse strand of burden

Educators play a key role in ensuring that the delivery of nursing and midwifery education is inclusive for all students (NMC, 2010). The findings of this study suggest there is a discourse which arguably is in conflict with inclusivity. Participants have found that talk around reasonable adjustments and support has been underpinned by a discourse of burden when students experiencing mental ill health have emerged. Reasonable adjustments and support was legitimised as a burden because they were practices considered to be in conflict with increasing work pressures.

This argumentation was based on personal experiences of workload, a feeling replicated in other studies. Mortimore (2013) reported the administration of needs assessments were found by lecturers to be difficult due to the extra support required and the increased work pressures resulted in having insufficient capacity and time to adequately support students. Sowers and Smith (2004) reported concerns raised by nursing faculty members with regards to the amount of time required to ensure the inclusivity of disabled students. Tee et al. (2010) found that the challenge to implement reasonable adjustments during nursing placements was attributed to the complex needs of the student, and may take up on average 20 per cent more contact time than their non-disabled peers. This tension has been illustrated among social work practitioners. Furness and Gilligan (2004) also noted the 'extra demands on the practice teacher's time' as a result of supporting disabled student social workers during their education.

The additional work pressures are not disputed here or within other research studies as it is widely reported that nurses and midwives workload have increased over the years (RCN, 2010). Francis (2013) and

Department of Health, 2016a) recognised that this has not been helped by a reduction in staff. The claims made by educators regarding workload are therefore unsurprising, but the argumentation allows students access needs to be placed low on a lecturers list of priorities and intensifies the blame onto the student. Limited attention is directed towards the economic and institutional factors widely reported throughout government and nursing and midwifery reports. This supports Mowbray et al. (2006) who argues that educators may see their role as more oriented towards the needs of the higher education institution.

The findings suggest that there is antipathy among educators, resulting in non-compliance of equality legislation. This resistance has been reflected in previous research studies. Riddell and Weedon (2006) reported students being told not to 'hassle' the educator when asking for support. This supports Clouder et al. (2016) who asserts that educators when referring to students with disabilities have illustrated a 'grudging compliance'.

To counteract work pressures, the findings illustrate how some educators understood reasonable adjustments, albeit for dyslexia, to be the same for all students as the examples given were frequently uttered. Also these adjustments were assumed to be the same for both academic and clinical settings. Once students with dyslexia were assessed and academic adjustments identified and documented on a Learning Support Profile form, educators spoke of 'cutting and pasting' adjustments when students began placements. This suggests that educators' construction of policy and procedural requirements supersede individual students' needs. It can be argued that the discourse contradicts the previous discourse of difference whereby the student with a mental ill health label is the exception, yet adjustments are the same for all students with disabilities. The findings indicate a disparity between other researchers' interpretations. For instance, Fuller et al. (2004) argues that reasonable adjustments should be carefully discussed and unique to the individual student. Sanderson-Mann and Candless, 2006) and Tee et al. (2010) asserts that adjustments should also unique to the educational setting.

It can be argued that stigma can reduce a willingness to invest time and energy into disabled students, but a discourse of burden has been observed by student participants during their nursing and midwifery placements. A student shared an anecdote about an observation during their placement. They witnessed a nurse implying that patients who have self-harmed were not as deserving as those with physical illnesses. The findings reflect Conlon and Tuathail's (2010) study which found negative attitudes among emergency department nurses' attitudes towards patients who self-harm. Anderson et al. (2003) reported nurses did not want people one the same wards as those with physical complaints.

The findings of this study not only demonstrate a bias towards certain patients, but the power of the discourse may influence a student's decision to disclose their mental ill health. Another student shared their experiences of negative attitudes towards patients with mental health conditions during their placement. As a result the student expressed a concern about disclosure and decided not to inform placement staff of her learning needs in relation to mental ill health. Similarly, Howlin et al. (2014b) reports that non-disclosure during nursing and midwifery education is partly dependent on nurse attitudes. Research suggests this is not exclusive to nursing and midwifery education within the UK as a fear of stigmatisation and non-disclosure have been reported in an Australian study. Brown et al. (2006) found that health professional students expressed concerns about negative attitudes from placement staff and felt that they had an impact on their self-esteem, confidence and increased stress levels. This reflects Shakespeare et al. (2009) who refers to a 'hidden curriculum' in that disabled nursing and midwifery students gain untaught and more persuasive information from educators than the taught curriculum. As a consequence, students may re/construct their own interpretation of mental ill health during their time on placement. As this study has identified an array of negative attitudes and stereotypical ideology, it is possible that mental health stigma will continue.

The power of the discourse is determined by endorsement by others. It can be argued that a discourse of burden is also reinforced within governmental policy. Reports on the prevalence of mental ill health predominantly begin

with, or at least is overshadowed by a burden on society, as opposed to part of society. This is illustrated by the Department of Health (2011b) who assesses the prevalence of mental ill health on the economic implications on productivity reduction. This report places as a secondary concern the implications of mental ill health stigma and distress on the individual person. A discourse of burden not only contributes to the continuation of focusing on what is wrong with the individual, but illustrates how the needs of students are not on a par with others.

7.4 How dominant discourses influence students

This, the final research question will explore how the dominant discourses above exercise power and influence students who have a mental health label. The complexity around language use and labelling contributes to a diverse interpretation of mental ill health, reasonable adjustments and legislative responsibilities which have contributed to or may disadvantage some students and not others.

A key finding from this study is how the medical model of disability is most prominent and reinforced within both verbal and written texts. It has the power to regard the student with a mental health condition as the problem and enable the suppression of social and institutional factors (Oliver, 1990) which may contribute to the barriers faced. This was especially illustrated by the employment of psychiatric categorisation. Each psychiatric label may enable an educator to acknowledge the experience of mental ill health, but a limited understanding may have contributed to educators being unable to express examples of appropriate forms of support. As a consequence, students have been prevented from receiving appropriate reasonable adjustments, a finding not evidenced within similar studies.

The power of labelling has been reported to have negative implications for self-stigma. For example one student verbalised a feeling of guilt for taking time out of university, but felt unable to disclose her mental health label for a fear of discrimination. This corresponds with Corrigan et al. (2009) who

reported that stereotypical predications associated with psychiatric labels may affect a student's self-esteem. It can be argued that this could potentially create a barrier to maintaining mental wellness or recovery as students are unable to talk about what may be important to them. Evidence suggests that people who have knowledge of and believe discriminatory and prejudicial attitudes may result in psychological effects (Pachankis, 2007). Ralph (2002) asserts that being able to talk about mental ill health and relate to others who may have a mental health label is beneficial for a person's mental wellbeing, but the findings suggest this is not experienced by students.

The same student when experiencing mental distress found it difficult to seek support from placement because a disclosure of a mental health label would be expected. As a result, the student was unable to access the support required due to non-disclosure. Label avoidance whereby the person does not seek help in fear of being associated with certain medical conditions, has been identified in other studies. The National Union of Students (2013) online survey reported only 10 per cent of students had access counselling despite the study's reporting of a significant number of students experienced mental distress during their time at university.

The findings identified the prevalence of an illness model of mental health which endorsed the adoption of a sick role. This model may be of benefit to some students, but it can be argued that it is untenable to assume this approach would benefit all students. Other studies found that an illness model can be detrimental to the person's mental wellbeing. Rathod et al.'s (2005) study focused on the influence of insight into one's mental health. The study found that adopting an illness model compounded patients' experiences of depression. Similarly, Yanos et al.'s (2010) study on the impact of illness identity on recovery reported further feelings of negativity which may lead to a worse prognosis. It can be argued that an illness model of mental health enables an identity of patient to overshadow the identity of student. As a consequence, the power of the discourse allows an ideology which accepts mental ill health as an undesirable identity. As such, Smith's (2009) assertion that the discourse has the power to make disabled

students passive and powerless targets of intervention is plausible as no student indicated a resistance.

It can be argued that a student's resistance may lead to punitive action as demonstrated by students' experiences during their education, but also the language use throughout verbal and written texts. For example the university's student fitness to practice procedures which state that failure to seek medical treatment may be perceived as unfit to practice which may result in being compelled to comply with medical intervention or result in failing the programme. The practice has the potential to go against the wishes of the student but it can be argued that an absence of reasonable adjustments may have contributed to the only option left for the student, which was to seek medical attention.

The findings indicate that educators reinforce the prevalence of mental health stigma also through non-resistance. Not only is this achieved through endorsing negative and dominant discourse, but as one lecturer acknowledged, the concerns raised about the consequences of disclosure, demonstrates how knowledge and power can result in acquiescence. It can be argued that a lecturer is in a position of power to challenge discrimination around mental ill health. Yet the lecturer's awareness combined with positional power does not alter the experiences of students. Instead the lecturer's awareness has the power to reveal to students that discrimination and mental health stigma is condoned and disabling barriers go unaltered.

It can be argued that a disclosure may also result in negative attitudinal responses. For instance the dominance of a discourse of dangerousness was presented as a legitimate predication of students with a mental health label. Foucault (1978) who asserts that mental ill health is perceived as a qualifier of dangerousness has been overwhelmingly found and confirms that prejudicial and stereotypical predications are prevalent among nursing and midwifery educators and students and reinforced by NMC policy. This and other dominant discourses within this study creates a dilemma for students who wish to access reasonable adjustments, as a disclosure may

result in being assumed as unfit to practice. An unwillingness of students to disclose their mental health labels has been expressed by student participants, partly as a direct response to stigmatising and discriminatory practices experienced in both academic and clinical settings. This reflects the work of Olney and Brockelman (2003) who found students with previous experiences of discrimination influenced their future disclosures.

Following a disclosure, the process which begins with the requirement of a medical certification to prove eligibility for adjustments inhibits the identification of appropriate adjustments which can be met immediately. For instance, one student considered having their designated break during placement may reduce tiredness, which the student recognised as a trigger for mental distress. This supports Grue (2015) who asserts that reasonable adjustments do not necessarily required medical discourse.

The implementation of adjustments within educational settings as laid out in legislation and educational policy indicates a willingness from universities and practice placements to create an inclusive environment. Despite being in statute for over a decade, the study was unable to identify any evidence which illustrated students with a mental health label accessed reasonable adjustments. This refutes Beresford et al. (2010) suggestion that a disclosure of mental ill health is considered beneficial as it can enable rights and entitlements to be met.

The study has found that a dyslexia only interpretation of reasonable adjustments have prevented students with a mental health label from accessing adjustments. It can be argued that the promotion of disability equality illustrated in policy and procedures is insufficient. This reflects the work of Foucault (1988) who argues that access is controlled by mechanisms of power by and dependent on educators' knowledge and understanding of mental health stigma and equality legislation. The findings reflect Sowers and Smith (2004) study who found that nursing faculty members reported a need for more training on legislative requirements around inclusivity.

However, the interpretation of reasonable adjustments for any student is underpinned by a medical model of disability. It is the student who is supplemented with particular interventions to ameliorate capabilities and bring the student in line with the dominant culture as oppose to examining an eradicating the barriers created within that culture. It is therefore argued that legislative information is linked with the social model of disability if training was provided. This is especially important as it is argued that a legislative based approach may reduce a discourse which reinforces personal deficiency and more towards social barriers and discrimination (Baylies, 2002).

As a consequence and articulated by one student participant, the lack of adjustments was thought to have increased mental distress which resulted in time away from their studies. This supports the work of the Royal College of Psychiatrist (2011) who reported that students with a mental health label are likely to take longer in completely their education. Sanderson-Mann and Candless (2006) argue that no adjustments or delayed access could be too late for adjustments to be effective for the student.

7.5 An absence of positivity attributed to disabled students

In line with a discourse-historical analysis approach, identifying the discourses absent from the study contributes to an understanding of the phenomena under investigation. The study has shown that student experience and knowledge of mental ill health are largely undervalued. It is argued that the focus is on what the student can and cannot do and is more prominent when it comes to talking about mental ill health. This does not correlate with the NMC who subscribe to and promote the benefits of having a diverse workforce in order to meet the needs of the community (NMC, 2010b). Only one student participant illustrated the positive contribution to the profession due to personal experiences and understanding. This is in line with Mortimore's (2013) study which reported a minimal number of students and one lecturer who gave a definition of

dyslexia indicating strengths. In contrast, Olney and Brockelman, (2003) found students evaluating themselves in a positive light and placed the problem with the environment. They reported one student who felt that it added richness to their lives while Illingworth (2005) argued that personal experiences of disability enables a greater understanding of patients' needs.

Research would suggest that student nurses and midwives hold a number of skills and strengths which have not been acknowledged in this study. Murphy (2011) found that some dyslexic radiographer students acknowledged their own strengths including organisational skills and developing own coping mechanisms. French (1988 cited in Abberley, 1992) reported how health professionals with disability labels can achieve good communication with patients and an increased understanding of needs due to a personal experience. Training alongside a peer who identifies with a disability label can be of benefit as stereotypical and prejudicial ideology can be directly questioned (Shakespeare et al., 2009).

7.6 Conclusion

This chapter demonstrates how the research questions have been addressed and presents an argument around how and why certain constructs of mental ill health have influenced the experiences of nursing and midwifery students with mental health labels. The complexity of all the discourses identified within this study has been illustrated with numerous examples. As a result, the chapter has been able to demonstrate how such findings have been reflected in the wider literature. Adding to the array of studies which focus on the experiences of students with disabilities, the exploration of discourse has enabled this research study to present additional insight. It is suggested that this contributes to an understanding of why experiences of discrimination and barriers around accessing reasonable adjustments have been reported in previous studies.

The chapter has argued that referential and predicational strategies used through language around students with mental health labels, reasonable adjustments and fitness requirements indicate multiple versions of reality. It has also been argued that interpretations of student mental ill health and reasonable adjustments have been repeatedly underpinned by medical discourses which support previous studies conducted within educational and clinical settings. The discussion has also established a discursive link between medical discourse and the absence of reasonable adjustments highlighted in the findings.

One of the main arguments which has transpired is that dominant discourses have exercised power and enabled the attention to be drawn to the individual student. The study has been able to show how dominant discourses allow the balance of power to remain with the educational institution and as a result, social and institutional barriers have been maintained. It has been suggested that this reflects the medical model of disability whereby the problem to be solved is placed with the students mental ill health.

Also reflecting the wider literature is the dominance of mental health stigma, illustrated through a stereotypical discourse of dangerousness. The literature suggests that this assumption of dangerousness has been discursively linked to mental ill health throughout history and the findings of this study suggest it will remain dominant in the near future unless mental health stigma is challenged.

Chapter 8: Conclusion

8.1 Introduction

The overall purpose of the study was to further the widening participation agenda (DfES, 2003; NHS, 2010) by illustrating how nursing and midwifery education can provide an inclusive learning environment. It is argued that this would not just enable students with a mental health label to reach their full potential during their education, but have an influence on future career opportunities which would enable security and add value to community and self.

This research has contributed to knowledge of how nursing and midwifery education understand and respond to students with a mental health label. Chapter two presents a historical overview of mental ill health and how society and institutions have contributed to and influenced the experiences of those considered to be mentally ill. This was followed by an overview of the literature around students with disabilities, nursing and midwifery education and equality legislation.

Chapter three has presented a review of the literature around attitudes towards mental ill health and other disabilities within nursing and midwifery practice and education. Previous research has indicated that discriminatory practices towards students with a mental health label and other disabilities were still prevalent despite equality legislation. Therefore as a disabled researcher, it was of interest to me to find out how talk and written text re/construct students who had a mental health label.

From a critical realist and critical discourse analysis approaches, it was important to conduct a study which contributed to the emancipation of students with a mental health label. By taking a discourse-historical analysis approach, the study has been able to illustrate the dominance of medical, difference and blame discourses identified in both participant interviews and policy and guidance documents which reinforce discriminatory ideology. The methodological approach was able to identify

how overt and covert discursive strategies used in language were utilised in order to legitimise claims and to make more persuasive argumentations around student mental ill health and reasonable adjustments. As a result, the study has shown how language used by participants and through written texts has been able to exercise power by influencing the absence of reasonable adjustments for some students.

The study's focus on dominant discourses around mental ill health, reasonable adjustments and fitness to practice requirements and how they influenced students during their nursing and midwifery education will be summarised below. The chapter will summarise the key findings and how they addressed the research questions.

To contribute to the credibility of the study, my own reflections on the research process, the study's transferability to the nursing and midwifery professions as whole and perceived limitations will be discussed. This will be followed by recommendations specific to education, clinical practice, policy and future research.

8.2 Discourses around understanding of mental ill health

Despite the widely accepted view of the social model of disability within policy and procedures, it is arguably ineffective in practice as the medical model of disability is still the most influential approach to understanding people who experience mental ill health. Chapter seven (see 7.2.1) argued that medical discourses were the most dominant, used by educators to re/construct and reinforce a narrow understanding of the students' experiences and needs. This was also replicated by students who acknowledged a biomedical discourse to explain their personal experiences of mental ill health (see 6.2.1). This finding supported by other literature (Beresford et al., 2010) suggests that medical interpretations are considered for some people beneficial but the discourse, arguably reinforced by medical power, maintains its unquestionability and individualistic perspective on mental ill health. This one-dimensional

interpretation has denied students opportunity to explored alternative definitions of self, be empowered and identify their own needs.

The requirement of a mental health label as stipulated in equality legislation (HMSO, 2010) demonstrates a power imbalance. It reinforces a system where others decide who should receive reasonable adjustments and in what capacity. However, the findings suggest that a requirement of a mental health label is unrelated to accessing reasonable adjustments as no mental health adjustments came to fruition. Therefore the question needs to be asked about the reasoning behind mental health disclosure and for whose benefit as a disclosure of mental ill health has real consequences for the student without any benefits.

The lack of understanding of mental ill health and the power structures within the academic and clinical environments enable the attitudes and agendas of others to take priority over students with direct experience of mental ill health. The findings illustrated that the presence of stereotypical discourses indicates that the nursing and midwifery professions are not immune to stigmatising others. As a consequence and supported in other literature, experienced stigmatising discourses have the power to silence students through non-disclosure (Tinklin et al., 2005; O'Toole, 2011).

The most dominant and arguably the predications most unsuitable for a career in nursing and midwifery practice were the stereotypical and pejorative discourses around dangerousness and an inability to cope with adversity. While resilience was considered absent in students experiencing mental ill health generally, the study found that the expectation of dangerousness was more directed towards some psychiatric labels than others which suggest a hierarchy of mental ill health. Combined with resilience, a perceived competence measure considered fundamental in nursing and midwifery, these discourses have been at the centre of educators and peers claims. This reinforced the predication that a student with a mental health label is unlikely to manage and provide safe practices to patients in their care. Both discourses have allowed the focus to remain on the student with a mental health label. This reinforces a perspective that

change to the student is necessary, but flaws within the environment and culture where resilience and patient safety is tested, needs to be jointly examined and changed (Storr et al., 2011).

8.3 The implementation of reasonable adjustments

This study has been able to show that legislative, policy and procedures promoting equality do not necessarily result in immediate action. The findings demonstrates how eliminating discriminatory practices within higher education and nursing and midwifery professions, despite being in statute for over a decade, is still a cause for concern. Since the introduction of the Special Education Needs and Disability Act 2001 (HMSO, 2001), it has been the role of higher education institutions to ensure students considered disabled as defined by statute are able to reach their full potential. To achieve this, those students eligible have a right to receive individualised reasonable adjustments both within the academic and clinical settings following a disclosure.

Chapter seven (see 7.2.1.2) argued that the dominant discourses highlighted in the study form a barrier to disclosure as students who are eligible and wish to access reasonable adjustments face a dilemma. The findings reflect previous literature which illustrates how discriminatory practice still prevails for some students (O'Toole, et al. 2011; Mortimore, 2013). Chapter seven argued that a possible outcome of a disclosure could result in stereotypical and prejudicial ideology being attributed to students, including dangerousness. The findings suggest that such a discourse was utilised when considering an assessment of being unfit to practice. This arguably was based on the educators' subjective knowledge and attitudes around mental ill health and fitness requirements (DRC, 2007).

Another probable outcome of disclosure, as illustrated in the findings (see 6.3.3) may result in students being advised to 'go off sick' and return when the experience of mental ill health has ceased as opposed to being referred to the disability service for an assessment of need. Chapter seven argued that educators' understanding and construction of disability could have

been influenced by medical discourses. Students' experiences were largely dependent on how their mental health was identified and interpreted and how these fit into the current understanding of disability. Chapter seven (see 7.2.1.3) argued that distinguishing between disability and mental ill health was one of many discursive strategies utilised. However, it is plausible that a lack of transparency within NMC documentation contributed to this interpretation, allowing for a prejudicial ideology of exclusion to be sustained. The concept of reasonable adjustments, its association with disability and the way in which disability and mental health has been linguistically separated has disadvantage some students more than others.

The study found that a willingness towards inclusivity predominantly concentrated on students known to be dyslexic. However no consensus around the understanding and implementation of adjustments for these students was evidenced. However, the study found that disability was synonymous with dyslexia and as a result, compensatory adjustments were provided in the shape of 'extra' support and time. It was argued that the dichotomy of mental ill health and disability was an exercise of power through the discourse, to the point whereby there was a consensus among educators and students that reasonable adjustments were exclusively for dyslexia. This interpretation of disability allowed some students to be disadvantaged compared to others. This study has argued that both dyslexia and mental ill health shared an underpinning medical discourse as the focus of change was directed towards the student. As a consequence, inaccessibility of the learning environment which arguably created disabling barriers was not endorsed by participants and documentation. The study has argued that the social model of disability was overshadowed by a medical model, despite its dominance within disability research and policy for decades.

The second option for students would be to not disclose, allowing attention to be drawn away from that person. However, the educators have indicated that this represents dishonesty, an act considered incompatible with 'good character' (NMC, 2010b). Despite these potential dilemmas faced by students with a mental health label the findings suggest the decision around

disclosure of mental ill health has no influence on accessing reasonable adjustments. It was argued that the majority of students with a mental health label received ad hoc support or none at all until they were 'floundering' as one participant expressed (see 6.3.3).

Finally, it was argued that language which indicated the presence of a large workload revealed an argumentation claim underpinned by a discourse of burden. This study has argued that the claim was endorsed to legitimatise the absence of reasonable adjustments and redirect responsibility towards the student whose non-disclosure was to blame. Here the educators revealed an unbalanced power relation as disclosure of mental ill health was evidenced within the findings.

8.4 Limitation of the study

An important part of any research study, especially those with a critical realist philosophical approach is reflexivity. Therefore I will discuss what I considered to be potential limitations which could have affected the findings despite the study being able to address the research questions.

In response to the university's ethics panel's request, the information sheets given to participants included a description that the study was going to analyse talk. It may have been possible that the quality of data was influenced by participants' knowledge that language use was the focus of the study. Similarly, I was very aware from the start that the language used during the interviews would inevitability influence participant responses. These included the term 'mental ill health' which could have contributed to the dominance of biomedical discourse. Listening back to the interviews, I did recognise a change in my language use to suit the language used by participants. However, it can be argued that my initial language use may have contributed to the continuation of the term for some participants.

Another perceived limitation was a concern that face to face interviews would have increased the potential for social desirability bias (Bryman, 2012). Social desirability bias is evident when participants provide responses that they think are acceptable and expected, potentially resulting

in a distortion of data. It was thought that participants may not be open to reveal language which may not be considered socially or professionally acceptable. It can be argued that the use of argumentation strategies which enabled participants to redirect responsibility away from self could reflect social desirability bias. It is also possible that participants may have answered some questions with the intention of protecting self from any perceived consequences. However, the findings also suggest participants were very forthcoming with discourses arguably incongruous with NMC, university and legislative policies.

With regards to the research sample, my intention was to obtain an equal number of educators from both academic and clinical settings. The pool of mentors which met the research inclusion criteria was substantially larger than the pool of lecturers. However the number of mentors in comparison to lecturers who participated was substantially lower. During information sharing sessions, a much more positive and avid feedback about the research was given within the academic setting. It can be argued that research or student mental health was more of a priority for academic staff, but the impression given during NHS information sessions was much more about time commitments. The limited number of mentor participants could have been as a result of their inability to spend time away from caring for patients during working hours, a position dissimilar for lecturers and students.

As a critical realist, it was important to obtain multiple forms of knowledge from different perspectives. Dominant discourses identified were utilised by all participants, but the limited number of mentors made it difficult to triangulate interview data among different groups of educators. It is plausible that the sample size of mentors could have influenced the quality of the data in respect to the knowledge and understanding of mental ill health. Whilst the sample size has enabled the research questions to be addressed, a construction of mental health and reasonable adjustments from mentors' version of reality is limited. It can be argued that this reduces transferability, in that the reader will be unable to apply generalisations

based on the language used by mentors to the wider population of nurse and midwife mentors.

Similarly, the new knowledge created in this study only derives from participants attending, employed by or working in partnership with one UK university. With hindsight I could have expanded the study to include other universities and clinical locations, which may have contributed to a better representation of the phenomena under investigation and improved transferability. With these reflections in mind, it has allowed me to identify and consider future research areas of interest which will be discussed below (see 8.5.4).

8.5 Recommendations

This study has demonstrated how equality legislation and policy are not adhered to and potentially not enough to ensure students with a mental health label can participate in an inclusive nursing and midwifery programme. It is argued that other approaches and strategies are required so that all students experience an inclusive education. This study has established four areas where improvements could be made in order to contribute to the inclusivity and celebration of diversity within the nursing and midwifery professions. Recommendations for policy, education, practice and future research will be presented below.

8.5.1 Education

It is recommended that universities and colleges create a working group of lecturers, mentors, disability service staff and students both past and present be set up to focus on reducing disabling barriers. This is aimed at education institutions at a local level but could be expanded and created at both regionally and national level. It is recommended that a working group is led by students who play a key role in the following.

- Disseminate clear and transparent information regarding equality legislation and the process of receiving adjustments to new students at the start of each academic year.
- The delivery of mental health stigma awareness raising within university and placement settings.
- Contribute to anticipatory adjustments through the involvement of programme design and development.
- Be a point of contact for student whistleblowing of discriminatory practices with both academic and clinical settings.
- Ongoing monitoring and evaluation of students with and without reasonable adjustments, with a focus on how effective they are towards inclusivity.
- Feed student led monitoring and evaluation findings into university, regional and national policy development.

The current process of ensuring mental health equality within education inevitability separates the educator from the student and as a consequence, reinforces an 'us and them' divide. It is argued that this is an obstacle which needs to be overcome in order to develop a more constructive dialogue between all stakeholders. It is recommended that students should play a key role in developing teaching and learning in both academic and clinical areas by sharing their experiences. An evidenced-based working group around inclusivity led by students would enable educators to continue to develop their understanding of the barriers faced by students while an openness of mental ill health is acknowledged and celebrated. Research suggests that contact with people who experience mental ill health on an equal footing has a positive impact on peoples' attitudes much more than other methods such as campaigning (Corrigan and Fong, 2014).

Considering there is no consensus about whether mental ill health is a disability or not, it is recommended that higher and further education institutions' disability service changes its name to the 'inclusion service'. Not only does this allow students to choose how they describe themselves (Sanderson-Mann and McCandless, 2006), but it lessens the confusion and

assumptions around certain disability labels. An inclusion service allows the focus to be on environmental and institutional barriers which corresponds to a social model of disability (Oliver, 1990) rather than the student's disability.

The study shows that a person with a mental health label is discursively linked to pejorative stereotypes, has no bearing on receiving reasonable adjustments and results in medical interventions. Therefore it is recommended that disability categorisations are excluded from information shared with academic and clinical educators and are only used to aid assessment of access needs conducted by the 'inclusion service'. This may allow students to make an informed and safe decision about requesting an assessment for reasonable adjustments.

The implementation of reasonable adjustments would still be a requirement for teaching staff, but the absence of a disability label would prevent stereotypical assertions being attributed to such labels. It would also enable students to maintain their privacy if they wish, but allow students who want to inform others of their mental ill health, to do so. This places the decision with the student rather than the administrative processes within the university and focuses on the changed needed to teaching.

As it is expected that students with a disability label will enrol on nursing and midwifery programmes, it is recommended that accessible and inclusive learning environments should be received by all students and not just those who disclose a disability. Therefore, a commitment to anticipatory adjustments would remove disabling barriers and reduce the need for individualised reasonable adjustments for some students (Tinklin et al., 2004). This allows the education system to make changes prior to students' enrolment and work towards eradicating a discourse which maintains the premise that the problem lies with the student. This approach could reduce a reliance on disclosure, but also encourage a discourse which reflects Read and Clement (2003, p.45) who assert that 'equal treatment is not a special dispensation available only if booked in advance'. An ongoing exploration of anticipatory adjustments could enable teaching and learning methods to adopt a social model of disability. The focus will be on structural

and institutional barriers and not the individual student's perceived disability. This would require educators and policy makers to be creative and not be trapped by traditional ways of working. An example of an anticipatory adjustment is a flipped classroom. The main component of a flipped classroom is to transfer the direct lecture to videos or reading prior to the lecture. This allows the lecture environment to become focused on more group-based learning while material needed is examined in the students own time at their own pace (O'Flaherty and Phillips, 2015).

Flexible placement arrangements could be made available. This could include placement locations nearer to where the student lives rather than having to travel long distances which could cause tiredness and/or stress. Educational settings could be more visible about positivity around mental ill health as well as potential concerns and supportive practices.

It is recommended that educators and students receive training which focuses just as much, if not more on social and institutional factors as opposed to only medical discourses. It is envisaged that this will have a positive influence on gaining an alternative understanding of mental ill health. This would include training underpinned by positivity in that students with mental health experience should be considered as a benefit to nursing and midwifery profession (Illingworth, 2005). The focus should be on what an accessible and inclusive environment can enable students to do rather than what their disability prevents them from doing. This applies to all disabilities but acknowledging that all students are different despite sharing common medical terms is important.

Disability equality training is not a new concept but the numerous sources of guidance and policy around anti-discriminatory practices including those available via the university and NMC indicates they are not effective on their own. One of the significant findings which contribute to the perpetuation of disability attitudes and is considered a major barrier to mental health equality is a lack of understanding and knowledge around mental health. The study has established a reliance on prejudicial discourses which have reinforced a correlation between unsafe and

incompetent practices and mental ill health. It is imperative that educators within both academic and clinical settings understand their legal responsibilities to not discriminate. This study suggests that mental health literacy is essential if educators are to provide a positive learning environment (Dale and Aiken, 2007) which reflects legislative obligations. It is suggested that educators and students require further knowledge around the different and conflicting interpretations of mental ill health and the implications on individuals, policy and practice. Educators and students need to be informed about how the language they use can have a detrimental effect on students they teach and that alternative discourses should be sought. It is envisaged that an increased awareness will reduce negative attitudes towards people who experience mental ill health.

It is important that training acknowledges that mental health stigma is not only portrayed by the media, but that educators are just as susceptible to reinforcing stigma and discrimination as the general public. Qualified and student nurses and midwives need to be knowledgeable that subscribing to negative attitudes may be detrimental to a positive relationship with students and patients and may perpetuate stigmatisation.

8.5.2 Practice

It is recommended that practice placements and the university develop their communication processes in order to ensure student access needs are explored with all stakeholders prior to the placement commences (Wray et al., 2005). This would enable the student and mentors to explore context-dependent reasonable adjustments in time for the students first day on placement. As my experience and knowledge is beyond the scope of nursing and midwifery practice, it is envisaged that the working group presented above (see 8.5.1) will explore better working relationships and systems are formed in order to facilitate a more inclusive learning environment.

It is recommended that the university and clinical placements have practice placement support agreements in place. This is an agreement which

documents the students' reasonable adjustments during their placement. To ensure this is successful, it is suggested that the student, mentor and lecturer meet before the placement begins to identify adjustments conducive to access needs and placement practice. To ensure continuity of inclusivity, regular appraisals should be undertaken when a student has a practice placement support agreement in place. This will allow for an evaluation of the implementation of reasonable adjustments for the specific placement as well as the individual student. This will allow an improvement of access both future students at that specific placement location, but also ensure changes to the students' next placement will be made in advance.

Despite the small sample size of mentor participants, the study has indicated through anecdotes from students and educators and by mentor participants that similar attitudes and understanding of mental ill health and reasonable adjustments are present within practice areas. Therefore it is recommended that mentors could benefit from participating in both the working group and staff training around mental ill health (see 8.5.1).

Finally, it is argued that while there are some similarities, the learning needs of students with mental health labels and other disabilities are idiosyncratic and diverse. Due to its complexity, there could be mentors whose role is to champion inclusivity of students. This could include taking a lead in ensuring student access needs are met and that clinical practices are evaluated with the intention of reducing the need for reasonable adjustments in the future.

8.5.3 Policy

To reduce confusion around the dichotomy of mental ill health and disability, it is recommended that NMC and university policy make it clear that mental ill health under legislation is considered a disability if the student meets the disability eligibility criteria. The findings have indicated an understanding of mental ill health to be transient. It has been argued that this adds to the confusion as it is unclear if mental ill health can be

‘substantial and long-term’ as stated in equality legislation (HMSO, 2010). NMC and university guidelines need to ensure that mental ill health even when managed by the individual, is still considered long term if the student has or will have a mental health diagnosis for more than 12 months.

It is also recommended that an alternative way of expressing the need for patient safety and the support of disabled students be presented as the current language is disabling (DRC, 2007) in that it may create contribute to a discursive link between disability and unsafe practice (Sin and Fong, 2009). The study argues that unsafe practice is not dependent on disability, but a competence measure fundamental to all students and qualified practitioners. NMC policy and guidance which details equality legislation around supporting disabled students should exclude adjacent language around ensuring patient safety. It is recommended that patient safety continue to be dominant within such documents, but not alongside text around disability and mental health.

8.5.4 Future research

This study has started to investigate the dominant discourses utilised within nursing and midwifery education around mental ill health and reasonable adjustments. The findings indicated that accessing reasonable adjustments were absent for students with a mental health label at a specific location in the UK. It would be of benefit to conduct a similar study across various geographical locations and other pre-registration programmes in order to find out if the findings of this study are representative of higher educational institutions and/or nursing and midwifery education. As a construction of mental ill health and reasonable adjustments from mentors’ version of reality was limited, it would be benefit to ensure their involvement in future research. Furthermore, this study has focused on students and educators, and so it would be beneficial to involve other people who are part of the process of implementation and assessment including staff members of

disability service, other non-mentor clinical staff, administrators and library staff.

Ijiri and Kudzma (2000) report that reasonable adjustments can enable student nurses with learning disabilities to reach their full potential, but it is unknown if the same can be said for students with a mental health label. Further research needs to explore nursing and midwifery educators and students perceptions of reasonable adjustments once implemented and experienced in both academic and clinical settings. For this to occur, it would be of benefit to conduct a longitudinal case study of students eligible to receive reasonable adjustments from enrolment to being qualified as a nurse or midwife.

The frequent use of language around dangerousness and unsafe practice suggest that further exploration about why this was dominant would be useful. The findings were unable to establish if these narratives had experiential substance. Therefore it would be useful to find out if concerns around patient safety and disability, including mental ill health have been evidenced by the NMC or other research or if the assertions are purely based on stereotypical ideology. Further research in this area would add to knowledge around the complexity and subjectivity of mental ill health and reasonable adjustments.

It may also be of interest to repeat this study but incorporate it into an action research project which begins with designing and delivering staff training based on the findings of this study. It would be of interest to explore the impact of training with a language base and information around equality legislation and mental ill health.

Appendices

Appendix 1: Literature review search strategy

	DATABASE								
1st stage SEARCH TERMS	Cinahl	Medline	AMED	ASSIA	Internurse	Wiley Online Library	**2nd Stage SEARCH TERMS**	PsycARTICLES	PsycINFO
Disability AND student	1660	178	234	7072	2574	125	Disability AND student	164	11739
Dyslexia AND student	1105	3497	63	288	42	91	Dyslexia	49	4236
Nurse AND disabled AND Student	91	178	9	397	2417	17	Nurse AND Student	10	99
Midwife AND disabled AND Student	0	0	0	46	183	0	Midwife AND Student	1	21
Disability AND Student AND Placement	0	6	16	979	1692	7	Student AND Placement	41	497
Fitness to practice AND Student AND Disabled	1	1	0	69	442	2	Fitness to practice AND Student	1	3
Reasonable	5	6	6	275	71	9	Reasonable	1	28

adjustments or accommodations AND Student							adjustments or accommodations AND Student		
Mental health AND Student	236	390	0	14008	3161	563	Mental health AND Student	526	17044
Mental health AND Student AND nurse or midwife	14	9	0	2949	3006	133	Mental health AND Student AND nurse or midwife	4	744

Appendix 2: Example of recruitment poster

Midwifery
Mentors Wanted

Exploring students', placement mentors' and university lecturers' understanding of mental ill health and reasonable adjustments and how this influences a student's ability to meet fitness to practice standards.

A great opportunity to take part in a research interview

How to participate:

Contact Jae Hargan on jmhargan@bradford.ac.uk

Tel: 07904245261 / 01274 236308

or your line manager for more information

closing date 3rd April 2015

Appendix 3: Student Information Sheet

Student Information Sheet

I would like to invite you to take part in a research study. Before you decide, I would like you to understand why the research is being done and what it will involve for you. I will go through this information sheet with you and answer any questions you have, if you wish. This will take about 10 minutes. Talk to others about the study if you wish.

Study Title: Exploring students', placement mentors' and university lecturers' understanding of mental ill health and reasonable adjustments and how this influences a student's ability to meet fitness to practice standards.

Researcher: My name is Jae Hargan and I am a research student at the School of Health, University of Bradford. This study forms part of my PhD studies and has been approved by the University of Bradford Research Ethics Panel.

What is the purpose of the study?

Students studying on a pre-registration nursing or midwifery programme are required to meet fitness to practice standards. Some students experience mental ill health while at university. Under the Equality Act (2010), universities are required to make reasonable adjustments so students diagnosed with mental ill health are not at a disadvantage compared to non-disabled students. Therefore I would like to find out if peoples' understanding and talk of mental ill health and reasonable adjustments influence students' ability to meet the fitness to practice standards on placement.

Why am I eligible to take part?

You have been invited to join this study because you are a nursing or midwifery student that requires you to take part in practice placements, be assessed against the regulatory fitness to practice standards and have completed at least one practice placement. Some of you are also eligible because you have disclosed your mental ill health to the university. I will also interview University of Bradford lecturers and practice mentors, so to gain their understanding about mental ill health and reasonable adjustments.

What would be expected of me if I take part?

The expectation will be for you to attend a one to one interview. This is not part of your normal university or placement time, so you would be interviewed outside of this time. However, the timing of the interview will be arranged so it is convenient for you. You will be asked to meet me once, for

about an hour, at a venue that ensures your anonymity. I will ask you some questions in relation to the study. I will not be asking you about your own personal mental health diagnosis and experience.

Do I have to take part?

It is up to you to decide to join the study. If you agree to take part, you will be asked to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect your own studies.

Will my taking part in the study be kept confidential?

All information you share during the course of the study will be kept strictly confidential. This includes your contact details. These details will be kept separate from any other data collected. The interviews will be digitally recorded and stored separately from your contact details, to ensure your identity is kept anonymous. The interviews will be transcribed and only shared with my PhD supervisors, Dr Christine Dearnley and Dr Melanie Cooper, but any data which may identify you will be anonymised. It is possible that Melanie recognises a student that she knows from the transcript. However, as you are discussing general understanding of mental health rather than personal experiences, this is very unlikely. She will not be reading the whole transcript, but only parts which relate to my analysis. The interviews will be transcribed by an independent person who will maintain confidentiality. The anonymised interview transcripts and recordings will be stored on password-protected computer and will be stored for up to 5 years and then securely destroyed/deleted. No names or other identifying information will be used in any supervision meetings, publications or final thesis.

I may unintentionally interview your lecturer and/or mentor without knowing. While they may talk about their own professional experiences, I will make it clear that no student names be used. The focus of the study is individuals' understanding rather than a study about a particular case or experience.

Please be aware, if you disclose any information regarding fitness requirements the NMC could consider as unsafe practice, I may have a responsibility to follow this up. In this situation, I would have to breach confidentiality but if this was to happen, I would remind you of this responsibility.

What will happen to the findings of the study?

As part of a PhD study, the findings will be written up as a research thesis. This will be submitted to the University of Bradford. An electronic and hard copy will be held by the university library. Also a number of articles will be

submitted for publication in relevant journals and possibly presented at conferences.

What are the possible risks of taking part?

Before taking part you should consider if participating will affect your own mental health. If you wish to discuss the study before or after, the disability office is aware of the study, but unaware of who is taking part.

What are the possible benefits of taking part?

The information from the study aims to improve the experiences of nursing and midwifery students with a diagnosis of mental ill, their lecturers and mentors.

Thank you for reading this information sheet. If you have any questions about any aspects of this study, please don't hesitate to contact me on 01274 236308 or by email jmhargan@bradford.ac.uk . Take at least 24 hours to consider taking part. If you would like to take part, please email me as soon as possible and return the consent form to me.

Appendix 4: University Lecturer Information Sheet

University Lecturer Information Sheet

I would like to invite you to take part in a research study. Before you decide, I would like you to understand why the research is being done and what it will involve for you. I will go through this information sheet with you and answer any questions you have. This will take about 10 minutes. Talk to others about the study if you wish.

Study Title: Exploring students', placement mentors' and university lecturers' understanding of mental ill health and reasonable adjustments and how this influences a student's ability to meet fitness to practice standards.

Researcher: My name is Jae Hargan and I am a research student at the School of Health, University of Bradford. This study forms part of my PhD studies and has been approved by the University of Bradford Research Ethics Panel.

What is the purpose of the study?

Students studying on a pre-registration nursing and midwifery programme are required to meet fitness to practice standards. Some students experience mental ill health while at university. Under the Equality Act (2010), universities are required to make reasonable adjustments so student's diagnosed with mental ill health are not at a disadvantage compared to non-disabled students. Therefore I would like to find out if peoples' understanding and talk of mental ill health and reasonable adjustments influence students' ability to meet the fitness to practice standards on placement.

Why am I eligible to take part?

You have been invited to join this study because you are a university lecturer for either a nursing or midwifery programme that requires students to participate in clinical placements and be assessed against the Nursing and Midwifery Council's (NMC) Fitness to Practice Standards. You may or may not have experience of lecturing students with a mental health diagnosis. I will also interview students with a mental health diagnosis and practice mentors, so to gain their understanding of mental ill health and reasonable adjustments.

What would be expected of me if I take part?

The expectation will be for you to attend a one to one interview. This may be during your normal working hours and place of work, but the timing and place of the interview will be arranged so it is convenient for you. You will be asked to meet me once, for about an hour, at a place that ensures your anonymity. I will ask you some questions in relation to the study.

Do I have to take part?

It is up to you to decide to join the study. If you agree to take part, you will be asked to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect your employment with the university.

Will my taking part in the study be kept confidential?

All information collected about you during the course of the study will be kept strictly confidential. This includes your contact details. These details will be kept separate from any other data collected. The interviews will be digitally recorded and stored separately from your contact details, to ensure your identity is kept anonymous. The interviews will be transcribed and only shared with my PhD supervisors but any data which may identify you will be anonymized. The interviews will be transcribed by an independent person who will maintain confidentiality. The interview transcripts and recordings will be stored on password- protected computer and will be stored for up to 5 years and then securely destroyed/deleted. No names or other identifying information will be used in any supervision meetings, publications or final thesis.

I may unintentionally interview students you personally lecture without knowing. While they may talk about their own experiences, I will make it clear that no names be used. The focus of the study is individuals' understanding rather than a study about a particular case or experience.

Please be aware, if you disclose any information regarding fitness requirements the NMC could consider as unsafe practice, I may have a responsibility to follow this up. In this situation, I would have to breach confidentiality but if this was to happen, I would remind you of this responsibility.

What will happen to the findings of the study?

As part of a PhD study, the findings will be written up as a research thesis. This will be submitted to the University of Bradford. An electronic and hard copy will be held by the university library. Also a number of articles will be submitted for publication in relevant journals and findings possibly presented at conferences.

What are the possible benefits of taking part?

I cannot promise the study will help you personally, but the information from the study aims to improve the experiences of nursing and midwifery students with a diagnosis of mental ill, their lectures and mentors.

Thank you for reading this information sheet. If you have any questions about any aspects of this study, please don't hesitate to contact me on 01274 236308 or by email jmhargan@bradford.ac.uk . Take at least 24 hours to consider taking part. If you would like to take part, please email me as soon as possible and return the consent form to me.

Thank you.

Appendix 5: Mentor Information Sheet

Hospital Trust 1 - Mentor Information Sheet

I would like to invite you to take part in a research study. Before you decide, I would like you to understand why the research is being done and what it will involve for you. I will go through this information sheet with you and answer any questions you have if you wish. This will take about 10 minutes. Talk to others about the study if you wish.

Study Title: Exploring students', placement mentors' and university lecturers' understanding of mental ill health and reasonable adjustments and how this influences a student's ability to meet fitness to practice standards.

Researcher: My name is Jae Hargan and I am a research student at the School of Health, University of Bradford. This study forms part of my PhD studies and has been approved by the University of Bradford Research Ethics Panel.

What is the purpose of the study?

Students studying on a pre-registration nursing and midwifery programme are required to meet fitness to practice standards. Some students experience mental ill health while at university. Under the Equality Act (2010), universities are required to make reasonable adjustments so students diagnosed with mental ill health are not at a disadvantage compared to non-disabled students. Therefore I would like to find out if peoples' understanding and talk of mental ill health and reasonable adjustments influence students' ability to meet the fitness to practice standards on placement.

Why am I eligible to take part?

You have been invited to join this study because you are a practice mentor for either nursing or midwifery programmes that require students to participate in clinical placements and be assessed against the Nursing and Midwifery Council's (NMC) Fitness to Practice Standards. You may or may not have experience of mentoring students with a mental health diagnosis. I will also interview University of Bradford lecturers and students with a mental health diagnosis, so to gain their understanding of mental ill health and reasonable adjustments.

What would be expected of me if I take part?

The expectation will be for you to attend a one to one interview. This may or may not be during your normal working hours and place of work, but the timing and place of the interview will be arranged so it is convenient for you. You will be asked to meet me once, for about an hour, in a place that ensures your anonymity. I will ask you some questions in relation to the study.

Do I have to take part?

It is up to you to decide to join the study. If you agree to take part, you will be asked to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect your employment.

Will my taking part in the study be kept confidential?

All information collected about you during the course of the study will be kept strictly confidential. This includes your contact details. These details will be kept separate from any other data collected. The interviews will be digitally recorded and stored separately from your contact details, to ensure your identity is kept anonymous. The interviews will be transcribed and only shared with my PhD supervisors but any data which may identify you will be anonymized. The interviews will be transcribed by an independent person who will maintain confidentiality. The interview transcripts and recordings will be stored on password protected-computer and will be stored for up to 5 years and then securely destroyed/deleted. No names or other identifying information will be used in any supervision meetings, publications or final thesis.

I may unintentionally interview students you personally mentor without knowing. While they may talk about their own experiences, I will make it clear that no names be used. The focus of the study is individuals' understanding rather than a study about a particular case or experience.

Please be aware, if you disclose any information regarding fitness requirements the NMC could consider as unsafe practice, I may have a responsibility to follow this up. In this situation, I would have to breach confidentiality but if this was to happen, I would remind you of this responsibility.

What will happen to the findings of the study?

As part of a PhD study, the findings will be written up as a research thesis. This will be submitted to the University of Bradford. An electronic and hard copy will be held by the university library. Also a number of articles will be submitted for publication in relevant journals and findings presented at conferences.

What are the possible benefits of taking part?

I cannot promise the study will help you personally, but the information from the study aims to improve the experiences of nursing and midwifery students with a diagnosis of mental ill, their lecturers and mentors.

Thank you for reading this information sheet. If you have any questions about any aspects of this study, please don't hesitate to contact me on 01274 236308 or by email jmhargan@bradford.ac.uk. You may also contact my academic supervisor, Dr Christine Dearnley on 01274 236449 or by email c.a.dearnley1@bradford.ac.uk. If you would like to discuss this study with an independent person, you are welcome to contact [redacted] (Practice Learning Facilitator) on [redacted] or [redacted] who has an understanding of this study. Take at least 24 hours to consider taking part. If you would like to take part, please email me as soon as possible and return the consent form to me.

Thank you.

Anonymity

Study and contact details will be on Blackboard

1

Exploring students', placement mentors' and university lecturers' understanding of mental ill health and reasonable adjustments and how this influences a student's ability to meet fitness to practice standards.

Jae Hargan
PhD Student
School of Health
Jmhargan@bradford.ac.uk
01274 236308

2

My background

- Learning Disability and Mental Health Advocacy
- I am independent
- I will not be assessing you

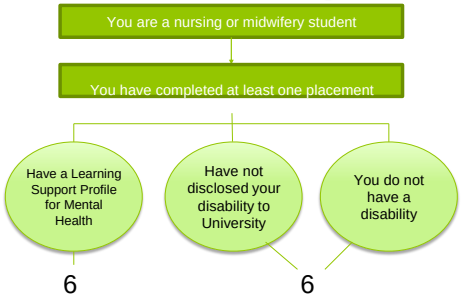
3

Purpose

- To improve learning and teaching within nursing and midwifery.
- To find out if people's understanding and talk of mental health and reasonable adjustments impact a student's ability to meet fitness to practice standards.

4

Who am I looking for?



5

Semi-structured Interviews

- Between 1 and 1 1/2 hours
- Quiet and anonymous room
- Questions not focused on experience

6

Confidentiality and Anonymity

- **Personal data collected**
  - Only on consent form
  - Mentor and lecturers anonymous
- **Interview venue**
  - Ensure anonymity and safety
- **What is not confidential**
  - Disclosing unsafe practice
- **Interview Transcripts**
  - Transcribed verbatim by an independent person
  - All identifying features will be anonymised or deleted
  - Academic supervisors may read parts highlighted in the thesis and publications
- **Data storage**
  - Personal data kept in a locked filing cabinet and only accessed by researcher
  - Interview data stored on a password-protected server
  - Stored for 5 years
- **Publication**
  - I will check with you that any direct quotes or descriptions are anonymised

7

Harm

- No questions will be asked about any personal experiences.
- Questions are focused on understanding of mental health, reasonable adjustments and fitness standards

Consider how taking part may affect your mental health

Benefit

8

Consent

- Participating in this study is voluntary
- No one should coerce you into taking part
- Read all of the information before giving consent
- You can ask questions at any time
- You will not be expected to give consent today
- You will be asked to sign a consent form
- You can withdraw at any time without giving a reason

9

Appendix 7: Consent Form

CONSENT FORM

Title of PhD study: Exploring students', placement mentors' and university lecturers' understanding of mental ill health and reasonable adjustments and how this influences a student's ability to meet fitness to practice standards.

Name of Researcher: Jae Hargan
Rm B1.21, Chesham Building, Faculty of Health, University of Bradford, Richmond Rd, Bradford, BD7 1DP; Tel: 01274 236308; Email: jmhargan@bradford.ac.uk

Please initial box

I confirm that I have read and understand the information sheet dated (date) for the above study.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that participation in this study is voluntary and that I am free to withdraw at any time without giving any reason.	
I understand that I am free to ask questions at any time. If for any reason I experience discomfort during participation, I am free to withdraw or discuss my concerns with the disability office, personal academic tutor, manager or anyone else I wish to talk to.	
I understand that the information provided by me will be held confidentially, such that the only person who can trace the information back to me individually is the researcher.	
I understand that should I disclose any information regarding fitness to practice that the Nursing and Midwifery Council could consider as unsafe, then confidentiality may be breached and the issue followed up.	
I understand that the interview will be recorded on a digital voice recorder and will be transcribed by an independent transcriber.	
I agree to allow my anonymised words to be used in reports and publications.	
I understand that the interview transcripts will be stored on a password-protected computer for 5 years and then securely destroyed.	
I would like a summary of the findings once the study has been completed.	

I,_____ (Name of Participant) consent to participate in the study conducted by Jae Hargan, Faculty of Health, University of Bradford.

Signature: _____ Date:_____

* When completed, a photocopy of this form will be given back to you. The original copy will be kept separate from any data collected so it will be impossible for your identity to be known by others.

Researcher signature: 

Appendix 8: Student Interview Guide

Interview Guide for Students

(Verbatim script) Good *morning/afternoon,* thank you for agreeing to take part in this interview. First of all I would like to assure you that you will remain completely anonymous. This includes both your name and any identifying factors within the transcripts, but also within the final thesis. I will not be asking you questions about your own personal mental health diagnosis. Is it alright if I record the interview and possibly take notes? If at any part of the interview, you would like to withdraw, you are welcome to let me know and I will stop the tape recording and the interview. Can I first ask what your understanding is of the nature of this study? Can you tell me what your understanding is, if any concerns with regard to unsafe practice occur during the interview?

Give interviewee some background of the interviewer.

1. Can you tell me a little about the course you are on?
    a. Which year are you in?
    b. What was it about *nursing/midwifery* that encouraged you to apply?
    c. Can you tell me about some of the placements you have been on since you started this course?
2. What is your understanding of mental ill health generally?
3. What are reasonable adjustments?
    a. What reasonable adjustments can be in place during clinical placements?
    b. If there is no understanding about adjustments during placements, ask what reasonable adjustments can be in place for academic work?
    c. How would you define reasonable?
    d. What is the process in order to receive reasonable adjustments?
        i. How can students access reasonable adjustments?

ii. How can students find out about reasonable adjustments?

e. What are your thoughts about your reasonable adjustments?

f. How do you think reasonable adjustments are viewed by others?

g. Do you think reasonable adjustments can help?

h. Is there any other support which may help students?

i. Is there anything which could hinder a student with a mental health diagnosis during placement? (e.g. attitudes, support, adjustments, mental health etc.).

4. Can you tell me about fitness to practice standards?

    a. How are students assessed against these standards?

5. Can you tell me your thoughts on whether the fitness to practice standards is compatible with students' diagnosed with a mental health condition and reasonable adjustments?

6. Do you have any concerns about the fitness to practice requirements?

    a. Can you tell me a little bit more about why you think this?

7. What kinds of improvements could be made to students diagnosed with a mental health condition succeed on placement?

8. Can I finally ask you if you think there is any aspect of supporting students with a mental illness that has not been covered in this interview?

Thank you very much for helping me and giving up your time.

Appendix 9: Lecturer Interview Guide

Interview Guide for University Lecturers

(Verbatim script) Good *morning/afternoon*, thank you for agreeing to take part in this interview. First of all I would like to assure you that you will remain completely anonymous. This includes both your name and any identifying factors within the transcripts, but also within the final thesis. Is it alright if I record the interview and possibly take notes? If at any part of the interview, you would like to withdraw, you are welcome to let me know and I will stop the tape recording and the interview. Can I first ask what your understanding is of the nature of this study? Can you tell me what your understanding is, if any concerns with regard to unsafe practice occur during the interview?

Give interviewee some background of the interviewer.

9. Can you tell me a little about your role within the university?
    a. How long have you been in that role?
10. If unanswered in question 1, can you tell me what your role is specifically with pre-registration students?
11. What is your understanding of mental ill health?
12. Can you tell me about how your division supports a student with a mental ill health diagnosis?
13. What are reasonable adjustments?
    a. Can you give me some examples?
    b. How can students obtain reasonable adjustments?
    c. How would you define reasonable?
14. Have you tutored a student with a mental illness? (if no, go to question 7)
    a. Can you share some of your experiences?
    b. Did the student/s have reasonable adjustments in place?
        i. Were these adjustments for academic work and/or placement?

ii. What was your role with regards to these reasonable adjustments?

iii. What are your thoughts about reasonable adjustments?

c. Do you think their placement/s were a success?

iv. Why do you think that?

15. (only if no previous experience – see question 6) What are the reasons for not having experience of tutoring a student with a mental illness?

16. Do you think there are students who have a mental illness, but choose not to disclose?

i. What are your thoughts about that?

17. Can you tell me about your *nursing/midwifery* profession's fitness to practice standards?

a. What kind of competences are you looking for when assessing students on placement?

b. How can a student demonstrate they meet fitness to practice standards on placement?

c. What is your understanding of the NMC's requirement for 'good health and good character'? (If not mentioned previously)

d. Can you tell me your thoughts on whether these fitness requirements are compatible with students with a mental health diagnosis?

18. (if not expressed above) Do you have any concerns about students with a mental health diagnosis meeting fitness to practice standards and 'good health and good character' requirements?

a. Can you tell me a little bit more about why you think this?

19. What kinds of improvements could be made to help you in your role when supporting students with a mental illness?

20. Can I finally ask you if you think there is any aspect of supporting students with a mental illness that has not been covered in this interview?

Thank you very much for helping me and giving up your time.

Appendix 10: Mentor Interview Guide

Interview Guide for Practice Placement Mentors

(Verbatim script) Good *morning/afternoon*, thank you for agreeing to take part in this interview. First of all I would like to assure you that you will remain completely anonymous. This includes both your name and any identifying factors within the transcripts, but also within the final thesis. Is it alright if I record the interview and possibly take notes? If at any part of the interview, you would like to withdraw, you are welcome to let me know and I will stop the tape recording and the interview. Can I first ask what your understanding is of the nature of this study? Can you tell me what your understanding is, if any concerns with regard to unsafe practice occur during the interview?

Give interviewee some background of the interviewer.

21. Can you tell me a little about your role within the NHS?
    a. How long have you been in that role?
22. If unanswered in question 1, can you tell me what your role is specifically with pre-registration students?
23. What is your understanding of mental ill health?
24. Can you tell me your understanding about how your department supports a student with a mental ill health diagnosis?
25. What are reasonable adjustments?
    b. Can you give me some examples?
    c. How can students obtain reasonable adjustments?
    d. How would you define reasonable?
26. Have you mentored a student with a mental illness? (if no, go to question 7)
    a. Can you share some of your experiences?
    b. Did the student/s have reasonable adjustments in place?
        i. Were these adjustments for academic work and/or placement?

ii. What was your role with regards to these reasonable adjustments?

iii. What are your thoughts about these reasonable adjustments?

c. Do you think their placement/s were a success?

iv. Why do you think that?

27. (only if no previous experience – see question 6) What are the reasons for not having experience of mentoring a student with a mental illness?

28. Do you think there are students who have a mental illness, but choose not to disclose?

a. What are your thoughts about that?

29. Can you tell me about your *nursing/midwifery* profession's fitness to practice standards?

a. What kind of competences are you looking for when assessing students on placement?

b. How can a student demonstrate they meet fitness to practice standards on placement?

c. What is your understanding of the NMC's requirement for 'good health and good character'? (If not mentioned previously)

d. Can you tell me your thoughts on whether these fitness requirements are compatible with students with a mental health diagnosis?

30. (if not expressed above) Do you have any concerns about students with a mental health diagnosis meeting fitness to practice standards and 'good health and good character' requirements?

a. Can you tell me a little bit more about why you think this?

31. What kinds of improvements could be made to help you in your role when supporting students with a mental illness?

32. Can I finally ask you if you think there is any aspect of supporting students with a mental illness that has not been covered in this interview?

Thank you very much for helping me and giving up your time.

Appendix 11: Documentary Analysis sample

Documentary Title	Author	Relevancy
Fitness to practice panel	University under study	In accordance with NMC (2008) Good Health and Good Character guidance, all universities are required to have a local 'fitness to practice' process and panel
Learning Support Profile form	University under study	Academic reasonable adjustments can't be implemented without one.
Practice Support Agreement form	University under study	Mentors, lecturers and students with reasonable adjustments on placement complete this form
The Code: Standards of conduct, performance and ethics for nurses and midwives (2008)	Nursing and Midwifery Council	Code of conduct students are assessed against
Standards to support learning and assessment in practice: NMC standards for mentors, practice teachers and teachers (2008)	Nursing and Midwifery Council	Standards specifically looking at how students can be assessed on placement
Standards for pre-registration midwifery education (2009)	Nursing and Midwifery Council	Standards for all midwifery education

Good health and good character: Guidance for approved education institutions (2010)	Nursing and Midwifery Council	Students with disabilities are assessed against this criteria
Standards for pre-registration nursing education (2010)	Nursing and Midwifery Council	Standards for all nursing education
Guidance on professional conduct: For nursing and midwifery students (2011)	Nursing and Midwifery Council	Specific guidance on conduct for students
Midwives rules and standards (2012)	Nursing and Midwifery Council	Standards and Rules specifically for Midwives

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